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UNIVERSITY OF WARWICK

Department of Continuing Education

**Public, Private and Personal : A Qualitative Study
of the Invisible Aspects of Health Visiting**

submitted by

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*A Thesis submitted in fulfilment of the requirements of
the degree of Doctor of Philosophy in Continuing
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ABSTRACT

This thesis shows how it was possible to listen to health visitors relate their personal views about their work in such a way that new insights on being a woman as a health visitor have been identified. This contributes to the debate about the 'invisibility' of health visiting as a reality and also shows invisibility to be a metaphor for care and the caring aspects of the work, for the management of personal lay knowledge rooted in experience and for gender blindness in client relations based in surveillance. It shows health visiting operating on three levels that represent the public face of the work, the private lay knowledge and the hidden personal feelings. The thesis highlights the importance of remaining open to new ways of viewing and interpreting practice and makes suggestions for educational changes in the preparation of health visitors.

The study draws upon qualitative data from semi-structured interviews with 35 health visitors. It examines ways in which professional and personal experiences contribute as resources to the activity of health visiting in a public work arena where the emphasis on identifying targets and measurable outcomes increased during the 1990s. The health visitors who participated in this research all identified private and personal experiences which contributed to the process of their work but without any model to validate these as legitimate resources for their clients. The findings suggest that without a transformed outlook these potential resources will continue to be hidden and undervalued.

The analytical tools, drawn from feminist theories of care, epistemology and power relations were each applied to the data and demonstrated ways in which feminist understandings could lead to a heightened sense of being a 'woman worker'. It is suggested that becoming more aware of gender in client interactions can lead to a model of practice which values the needs of women and would enable health visitors to improve their practices with women.

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CONTENTS

PART ONE : BACKGROUND TO THE STUDY

page number

CHAPTER ONE : INTRODUCTION

1 Overview and invisibility as a metaphor	1
2 Background to the study	7
3 Aims and purposes of the study	13
4 Theoretical basis of the study	16
5 Methodological approach	18
6 Organisation of the thesis	21
Conclusion	22

CHAPTER TWO : LITERATURE REVIEW

Introduction	23
1 Invisible : as an outcome of ill-defined core work	27
2 Invisible within varied definitions	36
3 NHS : Health visiting and visibility	45
4 Health visiting and gender	51
Conclusion for the way forward in the research	63

CHAPTER THREE : NATIONAL PRESSURES ON HEALTH VISITING

Introduction	65
1 NHS Pressures	67
2 Pressures from nursing	74
3 Gender Issues	89
Conclusion	94

CHAPTER FOUR : METHODOLOGY

Introduction	96
1 Qualitative research	97
2 Design issues	109
3 Developing the method	115
4 Sample design	120
5 Data collection	131
6 Analysis	135
Concluding comment	140

PART TWO : EMPIRICAL WORK

CHAPTER FIVE : CARE BECOMES VISIBLE THROUGH FEMINIST DEBATE

Introduction	142
1 Feminist ethic of care : the debate	145
2 Health visiting within a feminist ethic of care	151
3 Counter discourses to care and visibility	167
4 Emotional labour and the caring self	172
Conclusion	178

CHAPTER SIX : FEMINIST VIEWS ON KNOWLEDGE ARE INVISIBLE IN HEALTH VISITING

Introduction	180
1 Tradition and the complexity of practice: science and experience	184
2 Transformations and visibility : where trajectories of feminism and science intersect	200
3 Transitions and experience : making visible health visiting	209
Conclusion	219

CHAPTER SEVEN : EXPLORING THE CONCEPT OF SURVEILLANCE

Introduction	220
1 The Surveilled	223
2 As surveilled subjects : internalising the gaze	229
3 Power of the gaze	233
4 The gaze resisted	238
5 Health visitors : as surveillers	241
Conclusion	256

PART THREE : SIGNIFICANCE OF THE WORK

CHAPTER EIGHT: CONCLUSION : A NEW VIEW FOR HEALTH VISITING?

Introduction	257
1 Health visiting and the paradox of invisibility	260
2 The metaphor of ‘public invisibility’	264
3 The metaphor of ‘private invisibility’	269
4 The metaphor of ‘personal invisibility’	276
5 Integration and summary of new views	281
Conclusion	288

REFERENCES	290
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APPENDICES

- Appendix 1** The interview schedule for individual participants
- Appendix 2** The interview schedule for group interview
- Appendix 3** Letters of invitation to participate in the study
- Appendix 4** Informed consent form

LIST OF FIGURES

1	Matrix to relate type of information with a time frame	118
2	Attributes of sample size	121
3	Check list for categories and themes in each transcript	139
4	Invisible and visible work as a parallel activity	282
5	Transformed knowledge where invisible and visible work intersect	283
6	Interconnections between invisible and visible activity	284

LIST OF TABLES

1	Health visitor practice experience	129
2	Educational background in addition to health visitor qualification	130
3	Proportion of dialogue in the early interviews	133
4	Proportion of dialogue in the main study	133

CHAPTER ONE

INTRODUCTION

1 OVERVIEW AND INVISIBILITY AS A METAPHOR

It is surprising in this so-called post-feminist world, that feminist analyses are so few in health visiting research, in which a female workforce works mainly with women in their own homes or in clinical venues. This thesis argues for the integration of personal and professional self awareness of being a woman as a health visitor, making links with women through the contacts with infants and young children, who traditionally have been the primary focus of the work. Although essential to the well being of young children, this link with women has largely been invisible. The contact with the woman was not generally itemised as work within record keeping systems until the 1990's which has contributed to the invisibility of this part of health visiting. The thesis will provide discussion on how health visitors, mainly women, develop and utilise themselves as resources in their connection with women, both through the application of knowledge and through caring about clients. It will also show some of the tension in the interplay between being a service provider and a woman worker within the context of surveillance.

The empirical work was designed to explore the perceptions of health visitors about themselves and the management of their own personal - professional experiences

which contribute to their interactions with other women. It draws upon educational and feminist thinking about knowledge and self awareness, and seeks to develop and provide a theoretical view about a group of women workers who regularly engage with women clients on issues that cross the personal and professional divide. In educational research, Patton (1990) conducted evaluation research into a personal - professional divide following a group educational experience and concluded this as an 'artificial and arbitrary' divide. In a health visiting dialogue with clients the question of an epistemology that facilitates professional and personal experiences needs to be identified and a theoretical viewpoint developed. The interplay of personal development and professional requirements for client interaction are explored through the empirical work and the insights gained. From a feminist perspective, Harding (1987) discussed the lack of empirical work into women's own views about their experiences and suggests that there is lack of a theoretical basis from which women can understand themselves and the world. This study seeks to reduce this lack by its exploration of women workers' views about themselves and how they utilise their personal and professional experiences within a work setting. It also seeks to show inter-relationships between their view about their work, and to make application about future educational developments.

Invisibility describes the reality of hidden activity in health visiting, but in a metaphorical sense is used to explore the issues around invisible activity which may

have affected the health visitor's ideas about their role. It appears a useful device for examining the way in which health visitors appear to have underplayed the fact that they are women doing their job with women. Instead, there appears to be an emphasis on being an 'ungendered' service provider. The primary subjects within the study are female health visitors describing aspects of their work with children and adults within a changing National Health Service. They have been seen by me as women workers, although they have not always seen themselves as such. The metaphor of invisibility can be applied to this characteristic, which appears as a kind of gender blindness, as well as to aspects of the work which have been considered 'invisible'.

An argument will be developed that the invisible nature of much of the benefit of health visiting and its consequent undervaluing, are, in part, due to the gendered aspect of the work. The invisible aspect has traditionally been embedded in a work process rather than being an outcome or measurable product. For many years the recording systems for home visiting only allowed an entry for work with the child; work with the mother was an assumed aspect of health visiting when the child was less than one year of age and not separated out for individual attention in the recording systems. With the advent of computerised recording systems and codes for key types of work, this situation is changing to give an entry for each person who receives health care education, assessment, surveillance and other health visiting interventions.

Invisibility is featured variously in the literature:- as outcomes which cannot be measured quantitatively (HVA 1995), as a product of caring and emotional labour, only recognised when there is a problem (James 1989), as being sustained in policy matters for nurses (Davies C. 1995), as a normal feature for women workers whose role is to prepare people for another service; it is also apparent in the role mothers have in the progress of children in school (Smith D. 1987), and as knowledge embedded in clinical practice but hidden through the lack of language or articulation by nurses (Benner 1984) and by health visitors about their work (Chalmers 1990). It was also evidenced by a female doctor when she had no 'scientific' language to describe her interpersonal work with patients in a hospice (James 1989).

Health visiting is work undertaken mostly with women, by mostly women workers, regularly in the client's home and therefore is characterised by a number of features which contribute to invisible work. These features can be categorised under three headings, gender of the worker, institutional values, and setting of the work. As an example Smith D.(1987) argued that much work by women is invisible by its nature because it deals with complexities of life which need attention before the technical or scientific intervention can be accomplished, which is often performed by a man; evidence is brought to bear from research with nurses and social workers preparing clients for interview and treatment by a psychiatrist. A not dissimilar pattern is the distinction perceived in health visiting work and that of clinical medical officers,

where a range of less definable work was conducted by health visitors prior to the more definable and technical work of the doctor in the clinical setting (Mayall 1993). Institutional values may veil the work of women, and Smith D.(1987) argues that because institutions are selective in what is considered of value, the particular work processes of individuals can be lost, as in the situations just described. This theme was developed with respect to organisational issues and visibility of personnel within the National Health Service and also to the origins and conduct of health visiting (Davies C. 1995;1997; 2000). Davies combined the institutional value and gender by the argument that health visiting was conceptualised by men, bringing with this an implicit gendered view which still prevails in the workplace. Davies C. (1997) asserts that there was a diminution of health visiting and that it was not recognised as real work, this appears in a similar way to the example just given from Smith. Much health visiting is conducted within the home, and this setting is acknowledged as low status and more invisible than work within a clinical setting. Clinic work has been proposed as ‘an intermediate domain’ for the partial view of work in a public setting (Mayall 1993) but this does little to make health visiting more obvious.

Health visiting is part of the State provision of universal help to children through the child health surveillance programme which provides assessment of development, and a first visit for families with new babies (Audit Commission 1994). Health visitors endorse the view that their work is with all client groups, but the Audit Commission Glossary states that in reality the majority of the work is with families where there

are children under 5 years. It is not clear whether it is a function of the lack of recording systems that the adults within families have not been seen as part of the wider client group, or whether it was because there was no National Health Service plan to use this contact in a health related way and recording systems were not developed. Any health care for adults was seen therefore by health visitors as opportunistic contact, but not valued through the employing authority as part of their caseload with a time commitment attached. It could be argued that interaction with the parent/carer has therefore been seen merely as a vehicle to attain access to the child without a clear place in the NHS for the adult. Most health visitors, and some health authorities made provision for an adult or family record where ongoing needs were identified, but this has not been universal. During the 1990s the recording of adult visits through contact with families became more prevalent and more accessible. Computer assisted recording systems were developed, and data recorded may show that the scale of adult contacts contributes significant work, albeit tangential to the main focus of health visiting, which is the child. However it will be argued that the lack of recognition of the adult client group is linked to women's work, especially within the home, and that it is part of the invisible phenomenon noted above. In particular this is linked with the process aspect of the work rather than the measurable, outcome and product part of the work.

A motivating factor for this research was the realisation that women workers were visiting mainly women in their homes, but very little literature had been produced to

examine what this might mean for the profession of health visiting. A study on mothering had reported that life issues were at times far more important to the women than mothering in its narrow focus on the infant (McKee and O'Brien 1983). Yet this appeared not to have been discussed in health visiting literature. Even within the United Kingdom's largest nursing organisation a conference on women's health, in the late 1990's, did not call for papers from its health visiting branch to make a contribution. This demonstrates the scale needed for a significant shift in thinking in order to acknowledge and value the part of health visiting which is to do with women and has traditionally been hidden.

2 BACKGROUND TO THE STUDY

The complexity of human behaviour and learning as well as the complexity of health visiting provided the impetus for the study within the context of women workers. Firstly, an interest in self awareness prompted the work, linked to the question as to whether or not an integrated approach of personal and professional development was discernible in the health visitors' perceptions of their work. Secondly, a question was raised as to whether the work by health visitors with women was seen as significant in its own right, although it is acknowledged that access to the family and the declared focus of work is with children. It is noteworthy that health visiting, with its mainly female workforce and access to a mainly female population, is largely silent

on gender matters and women's health issues, although this is changing in respect of post-natal depression. Thirdly the possibility of identifying a relationship between the health visitors' perceived approach to women and a female-gendered model of professions also contributed to the development of the study. Feminist understandings is an area of current and expanding interest in nursing and midwifery research and policy debate which needs to be extended to health visiting (James 1989; Draper 1997; Davies 2000; Smith and Gray 2000; Peckover 1999).

It was considered that exploring some of these issues could provide an explanation for the undervaluing of health visiting, thought also to be related to the invisibility that is a feature with female professions and with work carried out in the private arena of the home. An ongoing problem in health visiting is that the job appears ill-defined to outsiders (Stone 1996), and to have little clarification on its core skills (Smith J.1996). The insights gained by health visitors through application of their learning, both from their own personal non-working life, and through their interaction with women in homes and clinics could make a valid contribution to the pool of knowledge being developed about women and their ways of learning as defined through feminist writings. The overarching context is initial and continuing professional education and recommendations from the findings need to be applied to specialist community nursing education and practice, in the aspect of public health nursing/health visiting (UKCC 1998).

This study acknowledges men in health visiting through topics discussed with female health visitors, but it does not seek to develop a view about the perceptions of the work by the male part of the workforce. The number of men as a proportion in health visiting increased slowly from 0.86% to 1.06%, in the six years from 1990 - 1995 and is currently 1.3% (UKCC 1995; 1999b). The introduction of men into health visiting followed the removal of a midwifery or an obstetric qualification as a pre-requisite, but the numbers of men have remained at this low proportion, tending to confirm that health visiting is a workforce of women who are, in the main, making contact with individual women or groups of women. The removal of a midwifery or obstetric qualification as a pre-requisite also removed a hurdle for female recruits and prompted a re-appraisal of the neonatal and midwifery aspect of health visiting.

Health visitors have frequently argued that the long term relationship with women is established through the early and intensive visiting of new-borns and any threat to this would have adverse effects. Two threats to this period of visiting have occurred, midwives may be commissioned to visit the new-born for 28 days following birth, instead of the usual 10 days, and secondly the NHS Reforms, which state that only the initial visit need be by a health visitor, with subsequent visits being delegated according to assessed need; implementation of these possibilities is on a local basis. Health visiting is engaged with other statutory changes which may also affect its focus and scope through legislation proposed by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. New categories of Specialist

Practice have been itemised, and health visiting has become one of eight Specialist Community Nursing practitioner groups, and as such, becomes subject to a common core and modular approach to education with the other groups, and was required to move to degree education by September 1997. This change incorporated an adjustment to the name, to become Public Health Nursing - Health Visiting. Also, as part of the UK health departments' review of the Nurses, Midwives and Health Visitors Act 1997, the proposal was that registration of health visiting as a new qualification should be removed. It was proposed that recording arrangements, on the professional register, as for the other specialist practitioners should apply to health visiting. However, due to intervention at many levels this was avoided and health visiting remains a registerable qualification. The context for educational preparation, and the content and processes of the job, while unsettling in the transition period experienced at this time, may also permit new models and concepts to influence practice. It is anticipated that this thesis will make a contribution to the ongoing developments in health visiting as well as to women workers and clients.

The period covered by this study has also seen intense changes within the National Health Service in which market forces and value for money became key issues in the new requirement of commissioning services through a purchaser - provider mechanism. Four terms of office by a Conservative administration 1979 - 1997 worked towards the implementation of market reforms and the objective of

amalgamating the administrative tier at district level, so that District Health Authorities and Family Health Service Authorities became 100 health authorities. The changes became known as the 'reforms' and gathered momentum following the publication of the 1989 White Paper, Working for Patients. For health visiting this focused attention on the need to be clearer about outcomes and value of the work, on the need to make transparent the work being conducted with families and children, and to account for how time was being utilised. A major marketing exercise was initiated by the Department of Health (1994, England) in order to assist health visitors and health authority providers to identify their work so that purchasers, for example general practitioners, would be better able to understand the work which was on offer from the health visiting service. This marketing exercise revealed the Department of Health view that health visiting had been largely invisible and lacking clear outcome measures and achievements. However the emphasis on outcome measures and evidence based practice becomes problematic when seeking to establish that a process of experience and interpersonal self awareness can also be regarded as fundamental to the work, taking time and effort without necessarily being recorded. In view of the changed administration in 1997, this thesis also contributes to knowledge about the unexpectedly brief period of time between 1989 and 1997, when the NHS Reforms were being introduced.

A new Labour government was formed in May 1997, and many of the administrative changes have been retained and/or modified within the introduction of The New

NHS : Modern and Dependable (DoH 1997). There is a continued emphasis on measurement of outcomes which maintains the pressure on health visiting to reveal its work and be more transparent in its achievements. Also endorsed is the emphasis on public health and targets for health improvement, which also links with aspects of health visiting. Primary Care Groups and Clinical Governance are part of the modernising process and have relevance to the way health visiting is conducted (DoH 1998b; 1998a). In addition to these policy developments there is a new emphasis on human resource planning which will evaluate current roles as well as propose changes to the delivery of services (DoH 2000a). Transparency as a motif in the Government reviews will be addressed indirectly, by attempts to show more fully the work undertaken; the concern is that it will squeeze out the kinds of care work and search work which arise within a health visiting contact and which cannot be known in advance of that contact (Cowley 1995b; Elkan et al 2000a). This issue will be returned to during the debates within the thesis. Consequent upon government evaluation of roles, there will be new proposals for the educational development of all NHS staff, requiring some kinds of change, which are already known to emphasise teamwork, multidisciplinary links, user involvement, flexibility and will be more obviously keyed into local plans, Peach Report (UKCC 1999a).

3 AIMS AND PURPOSES OF THE STUDY

The purpose of the study is to explore the perceptions of health visitors about themselves as practitioners interacting with women, and how this contributes to the invisible aspects of the work. A working hypothesis has been that health visitors exercise caring and 'emotional labour' in their relationships with women, and this is instrumental in the production of health outcomes in the family, but is not identified in the process which achieves health related changes. The concept 'emotional labour' was applied in hospice work by James, she noted that the interpersonal, caring aspect of the work often remained invisible (James 1989). This concept has been further explored in nursing by Smith P (1992) and Smith and Gray (2000) who reconfirmed the invisibility and lack of a language to utilise emotional labour as a resource for practice. There remains a need for this to be included in nurse education and not 'discounted as "women's work"' (Smith and Gray 2000:73). Extrapolation from this indicates that the interpersonal work in health visiting can be present but unrecorded, invisible and thereby undervalued. Caring as a concept is not traditionally discussed in health visiting, which has the facilitation of health rather than 'care' at its centre. However feminist analyses of caring and a new paradigm of a feminist ethic of care suggest that caring and care are integral to the activity of health visiting, albeit without a vocabulary to reveal its presence (Fisher and Tronto 1990; Gilligan 1998).

A second hypothesis has been that there is an interplay between the scientific knowledge gained through the educational processes for the job and the private and personal knowledge gained through life experiences. This is rarely spoken of in health visiting - when it is, the suggestion is generally denigrated as unscientific and condemned as bringing subjective elements into the work which could bias or 'cloud' assessment and plans for problem solving. A context for the exploration of health visitors' views and women's perceptions is provided through a feminist approach to experience and science and epistemology (Harding 1987) in which there can be transformations of knowledge at intersections of previously held views with those from a new perspective or position. The concepts of personal and subjective work within the context of institutional requirements are also linked with the paradoxical aspects of learning and application to practice (Jarvis 1992).

Thirdly, a working hypothesis has been that there is tension between a personal approach to women and the overarching NHS, with its perceived task of achieving an 'objective' and measurable outcome as one of its commissioning variants. The concepts of surveillance and the monitoring mechanisms that form part of the working life are explored and related to issues of power and control. Issues of power and control are integral to a feminist exploration of relationships and these are considered within the context of discussion about Foucault and his discourses on power (Ramazanoglu 1993).

An aim for the study has been to uncover and make transparent some of the daily work of interactions which are essential in health visiting, but largely assumed as implicit to the job. Research questions have provided a framework for the inquiry, and gave direction to the literature review and informed the methodology.

- 1 To identify ways in which health visiting has changed over time from the perspective of experienced health visitors
- 2 To identify ways in which health visitors consider their practice to have been informed through both professional experience and personal life events
- 3 To discover how health visitors perceive their relationship with women
- 4 To utilise concepts from feminist literature in explanation
- 5 To evaluate the value of this exploration for the practice and education needed for health visiting

Since the overarching aim for the study was to discover how health visitors perceive their own practice, and to gain insight into some of their personal and professional influences on the process of health visiting a method that permitted exploration and

analysis of practice was needed. A broad approach in the qualitative tradition was seen as the most suitable to provide new data in areas not previously explored.

4 THEORETICAL BASIS OF THE STUDY

Early on, when thinking about the advantages and disadvantages of researching from a position of knowledge about health visiting, the theoretical discussions in scholarly writings about making the ‘familiar become strange’ were important. My work as a health visitor and as a lecturer in health visiting had given me an ‘inside’ view of health visiting and I was interested in how I could achieve a more ‘distanced’ view that might lead to unexpected insights. Of particular influence was Delamont (1992) who suggested a gender lens as a useful device for facilitating a new understanding about the topic for research. The term ‘lens’ appeared as an acceptable orientation, more neutral than an ideological stance and permitted a way of having a main theoretical focus plus subsidiary orientations rather than one fixed perspective (Patton 1990).

This position of a gender lens provided the basis for identifying the key concepts and variables to be explored through the data collection. It also located the stance for analysis. Patton argued that the extent to which a lens and a full orientation operated was a matter of degree and interpretation. Therefore a gender filter was used to

explore experience and interpersonal activity; it offered a way of seeing health visiting as gender specific rather than as gender neutral. Also to explore the way in which health visitors tend to speak of offering a service, as though disembodied from themselves. Further exploration of gender issues in health visiting revealed that little emphasis had been given to this dimension of the work and that the work seemed to be largely regarded as neutral or ignored.

A theoretical basis for lack of emphasis on gender, was found in Dorothy Smith's analysis of the academic world, which at first she considered to be genderless, but which with a gender lens was seen afresh. Smith then identified a male-gendered scene, developed by a male world view which pre-supposed agreement and gave no opportunity for any alternative explanation (Smith D.1987). The NHS, seen as a gendered organisation contributes a similar theoretical base to the research (Davies C. 1995) in which health visitors work may be taken for granted, hidden and therefore invisible.

Within the Continuing Education arena work-based learning and formal learning are incorporated within Continuing Professional Development, and this will provide a context for linking themes on work-based learning and perceptions. A complex interplay of personal and professional experiences are hinted at by Eraut (1994) as a basis for decisions about continued professional learning and work-based development. The inter-relationship of the personal self and the professional self has

also been of interest in feminist qualitative analyses and these concepts are applied in the concluding chapter of this thesis (Edwards and Ribbens 1998). Application of the outcomes of the study to health visitor education have been considered throughout the discussions and more formal recommendations are made in the conclusion.

5 METHODOLOGICAL APPROACH

With the study focus and research questions based in individual perceptions by practitioners, a qualitative approach, grounded in the real world, and allowing an interpretative analysis was prepared as the research design. The decision about the methodological design was informed by debates about the nature of qualitative research, and its evolution within different disciplines. Initially the structured view suggested by Miles and Huberman (1994), with their social psychology and educational backgrounds provided a way of developing a conceptual framework for the study, while staying within a qualitative mode. The view which demands orthodoxy of method seemed unhelpful for this study. In the nursing literature, for example, Baker et al (1992) discussed the grounded theory and phenomenological debates with outcomes in 'muddled methods'; they appeared to reject any claim of an evolving methodology. Greater affinity for this study was seen with Patton (1990) an educationalist, and Crabtree and Miller (1999) both medical practitioners in primary

health care, who demonstrate with Miles and Huberman, how qualitative, in-depth research can evolve and be applied in a systematic manner. In addition feminist traditions were integrated into the research design.

The application of a gender lens as an orientational device to guide the research design and theoretical framework was introduced, and gradually it became apparent that feminist values were underpinning the research and influencing the methodology so that this has become integrated within the overall approach. Feminist methodology, as a theoretical framework employed in research (Harding, 1987), appears to be operationalised on a continuum from strict criteria discussed by Webb (1984) to sets of principles which are flexible (Hall & Stevens 1991; Seibold et al, 1994). Common elements appear to be female experiences as central and valued, that can be seen as common feminist values and there should be a goal of producing change in women's lives (Jayaratne & Stewart, 1995; Draper 1997). The development of the methodology, methods and epistemology are discussed in the methodology chapter.

Interviews were seen as the most relevant tool within the research design, giving opportunity to explore the views of health visitors through conversation (Burgess 1984) and also to fulfil the task suggested by Blumer (1978:40) of using a tool which allows the researcher to discover aspects 'beneath those known to his informants'. This was seen as a critical requirement in the goal of exploring aspects of health

visiting not regularly discussed and therefore not at the surface of awareness. Interviews were standardised through a schedule formed from the conceptual framework which is considered by Marshall & Rossman (1995) to be particularly important to reliability and rigour when interviewing is the sole method of data collection. Standardisation also supports the defining characteristic of ethnographic interviewing which is described by Hammersley and Atkinson (1983:152) as 'standardised and reflexive' rather than 'structured and unstructured'. As the interviews took place over time there were some adjustments to the interview schedule, in keeping with researcher reflexivity, but maintaining integrity with the areas of interest, the focus of the study and the conceptual framework. The interview schedule from this perspective has remained 'standardised', covering the same data, but not so tightly structured that movement for participants and researcher was inhibited.

Analysis followed the requirements for all data, the first level was managing the data through reduction, organisation and description; the second was analysis and interpretation (Polit and Hungler 1999). Identifying patterns and developing category systems to show what was found in the data was through a systematic approach in which units of data were sorted into categories and themes. Data reduction included extraction of participant's views into individual summary files as the main categories and themes became evident. Working from the data, without pre-conceived codes gave opportunity for a comprehensive and open approach to the

transcripts, which was supported by sensitising concepts from the literature and summaries of each individual transcript. Both Patton (1990) and Miles and Huberman (1994) emphasise the separation between the organisational aspect of analysis leading to description, and the explanatory and interpretative aspects which arise from the conclusions drawn.

6 ORGANISATION OF THE THESIS

The thesis is organised into three parts, with eight chapters. Part One, Background to the Study provides this short introductory chapter, the review of relevant literature, the context and pressures of the National Health Service and educational issues, and the methodology for the research. The key concepts introduced in this chapter are developed in the remainder of Part One, which also provides the context and inter-relationships of health visiting, personal and professional learning, feminist insights and methodological decisions. Part Two is the heart of the study, comprising chapters five, six and seven in which the empirical work is described, data presented, focused and integrated with analytical insights and interpretation. Part Three, chapter eight, discusses the significance of the work and concluding applications in which relevance of feminist explanations for curriculum and self awareness in health visiting is developed.

Conclusion

This thesis shows how it was possible to listen to health visitors relate their personal views about their work in such a way that new insights on being a woman as a health visitor have been identified. This contributes to the debate about the ‘invisibility’ of health visiting as a reality and also shows invisibility to be a metaphor for care and the caring aspects of the work, for the management of their personal lay knowledge rooted in experience and for gender blindness in client relations based in surveillance. It shows health visiting operating on three levels that represent the public face of the work, the private lay knowledge and the hidden personal feelings and offers a feminist analysis as an explanation for how this happens in practice. The thesis highlights the importance of remaining open to new ways of viewing and interpreting practice and makes suggestions for educational changes in the preparation of health visitors. The literature review explores in more detail a number of issues which have been introduced in this chapter.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This thesis explores the invisible nature of health visiting. It aims to place the less measurable aspects of health visiting at centre stage. To go beyond the formal position of the NHS in its focus upon measurement and consider how it is that health visitors appear to be having difficulty in identifying their role and value. In so doing a gender lens will be applied by drawing on feminist literature to contribute an explanation for some key questions raised. What are the invisible processes utilised by health visitors? How do health visitors use themselves as resources in their work? Why is it difficult to comply fully with the current emphasis on measurement in the work? Could power relationships and surveillance of the work be examined through the Panopticon gaze? How do health visitors demonstrate their care towards clients?

There has been very little work from a feminist perspective to analyse the working practices of health visitors apart from one recent study which analysed practices of health visitors and women experiencing domestic violence (Peckover 1998). Prior to that the key work has been scholarly discussion in respect of the historical and gendered development of health visiting by Davies C.(1988; 1995; 1997); Orr in the 1980s (1986) who conducted research into women's health needs and health visiting; occasional mention of caring or gender related issues within studies

conducted by health visitors (Chalmers 1990; Cowley 1991; De la Cuesta 1992;) research by non health visitors (Mayall 1993). An occasional article which linked gender, education and the workplace (Rolls 1992) and a few articles which raise questions about the effectiveness of health visiting with particular groups of women - single mothers, women subject to domestic violence and women needing support with child protection issues (Peckover 1999; Frost 1999; Knott and Latter 1999). This lack has been surprising in view of the fact that health visiting is primarily a work force of women whose clients and contacts are primarily women. Recently there has been more interest in feminist analyses in nursing, midwifery and health visiting (Webb 1984; Draper 1997; Smith P.1992) but it remains an under-developed research area in these female dominated workforces.

In contrast to the lack of critical feminist explanations for the way in which health visitors view themselves there have been criticisms levelled at health visitors for their lack of meeting the perceived needs of clients (Mayall 1993; Kendall 1991). Also criticism for the amount of advice giving and evidence of resisting this in health visitor - client relations (McIntosh 1986; Heritage and Sefi 1992). The existence of this literature is indicative of the problems which health visitors face in their work and which contribute to the criticism that health visitors make little discernible difference to the health of individuals and families and therefore as a workforce could be reduced, in for example what has become known as the 'Cambridge Experiment' (Allen 1998) . Unfortunately, whilst the work of such 'experts'

contains examples of health visiting difficulties, the role of critic does little to explain what the health visitor was doing or feeling.

The critical dimension contained in these works tends to locate the health visitor in the 'advice giving' work of infant needs. There is also criticism levelled at the aspects of the work which are most strongly related to the 'state intervention' and so, by implication, the health visitor and her role is criticised. The increased emphasis on planned numbers of contacts, systematic recording of topics and surveillance highlights the pressure for more visible work and accountability exerted through two government administrations. The personal and professional process work, largely invisible, still appears unaccounted for in the new era (Stone 1996; Traynor and Wade 1994; Traynor 1993;).

Thus, when it comes to the invisible aspect of health visiting the 'experts' have identified its existence, but have done nothing to classify it or find ways in which it should be incorporated into the pattern of accountability or education through models of practice. Essentially, the 'experts' give advice which pressures health visitors towards more explicit service without finding ways to utilise the caring and relational aspects of their work, which this thesis suggests is integral and largely invisible and not counted.

Given that the largest proportion of literature on health visiting ignores any gender interpretations of the process of the work, my aim is to indicate that this lack has left many important questions unanswered. These questions relate primarily to the ways in which there is an invisible process which the health visitor brings to her work, through experiences, a desire for quality work, and values of care and caring. Further, the complexity of the working practices have largely been subsumed under broad categories of activity which are treated unproblematically by the employer and the practitioner. If there is to be an understanding of the health visitor which goes beyond the current emphasis on input activity and outcome measures, and which sees relationships as a means to an end and does not acknowledge the place of care, it is essential to bring a different form of theorising to the invisible dimension.

The major arguments and theories of invisibility in health visiting relate to the historical context and interpretation of the work, are concerned with output within the context of the NHS and have avoided gender issues. It is with this latter category that feminist literature can contribute explanations for the invisible nature of health visiting. Three areas of feminist interest are developed within the thesis, and seek to show how more emphasis on feminist theories could contribute to making parts of health visiting more visible and effective in its operations. An examination of care and how it could be made more visible in health visiting is considered from the feminist ethic of care literature. Exploration of a feminist reading of the inter-relationship of science and experience in which women, as

health visitors, could utilise their personal resources with clients is developed. Thirdly, an examination of the power relationships in health visiting will be considered from an understanding of surveillance, the Panopticon gaze and the binary system in feminist poststructuralism. An analysis of each of these highlights the gaps in our knowledge. Prior to this exploration an analysis of health visiting demonstrates current understandings and issues.

1 INVISIBLE : AS AN OUTCOME OF ILL-DEFINED CORE WORK

1.1 Invisibility within the historical context and interpretation of health visiting

The lack of being able to identify core work and its effect in producing a kind of invisibility around the focus of the work is discussed as a basic difficulty in health visiting. It will be seen that this is both by scholars external and internal to the profession. The discussion will incorporate views from a number of fields of study, for example from a gender analysis, a trade union history and the regulatory body as well as from health visiting researchers. The apparent lack of effective outcomes, of appearing less than visible, has resulted in some current employers questioning the necessity of health visitors. A radical cut back on numbers of staff has taken place in some health authorities, notably Cambridgeshire (Allen 1998).

One of the particular features in the analysis of health visiting and its invisible nature has been to distinguish between relationship based work and problem based work (Robinson 1982). The central feature of the debate has been to distinguish between the *internal* processes which are used to accomplish health related changes through personal links with the client and the *outward* measures of completed work. Nevertheless the debate is contradictory and its conflicting nature can be seen in part as to whether the focus of a given study is the process of the work or the product seen in the outcome, further complicated by the fact that there is doubt as to whether health visiting can be measured. In particular Davies C. (1997) noted that health visitors have raised questions about the nature of their work both from a legitimacy point of view, and also they continue to raise issues about the work being 'untestable' (Luker and Chalmers 1990; Dingwall and Robinson 1993; Cowley 1995a).

The work by Davies C, which concentrates on the historical development of health visiting and the gendered nature of nursing, argues that health visiting has not managed to provide a clear account of its work,

One hundred years on, we still have not found ways to bring fully into the open and confront a partial vision of what the work of health promotion entails. Working more directly with concepts of gendered thought may provide a way to get to a better understanding of what it is that health visitors do, and give it appropriate value and acknowledgement. (Davies, 1997:111)

A lack of core skills and responsibilities was identified by Smith in the history of the Health Visitor Association. So much so that there were calls in the 1970s for the Health Visitor Association to set out a Charter in respect of the 'proper functions' of the health visitor; this resulted in two documents each prefaced with a statement that affirmed the difficulty that health visitors had in describing the 'fundamentals' of the work, but setting out some of its key features (Smith J. 1996 : 49). This contrasted with work by the Council for the Education and Training of Health Visitors', who similarly concerned about the definition of health visiting, argued for Principles of Health Visiting on which to base the work. These were the outcome of a series of national workshops, embracing educationalists, practitioners and managers and resulted in the publication of a document setting out and debating the 'Principles of Health Visiting' (CETHV 1977). Twenty years later these Principles were re-affirmed as a suitable basis for health visiting work (Twinn and Cowley 1992). However the stark conclusion in 2000, was that no satisfactory model existed for health visiting, 'There is currently no definitive model of effective health visiting' (Office for Public Management 2000). All these 'experts' point to health visitors being a group for whom the ambience is indistinct and whose mechanisms for working are indiscernible. Yet these practitioners have been educated within Higher Education almost since the inception of health visiting, with a re-newed syllabus in 1965 which held sway for thirty years and have been constantly employed at a higher starting salary grade than district nurses, midwives or most ward managers in the hospital sector.

Finally it is little surprise that there are polarised views by non-health visitors which can be identified against this back drop - those who applaud work done and those who are sceptical of anything being achieved (Healey 2000). The efforts to produce a satisfactory model which now incorporates measurement of activity or achievement, on this evidence, will still not be sufficiently explicit for analysis to show the process of work. In particular there are too many anomalies to treat the invisible process as unproblematic. For these reasons it is important to overcome the dichotomy between product and process and to consider how health visiting could incorporate both dimensions. This thesis seeks to show that an analysis of the work based in feminist theories can incorporate these two dimensions which represent the more and the less visible aspects of health visiting. In addition to the contradiction and confusion in the literature on the core role of health visiting, the literature is equally confusing in its discussion on the definition and therefore place of health visiting in the health arena.

Before moving to explore different definitions of health visiting, the next section reviews some of the epistemological aspects of health visiting. In particular the effort to be scientifically credible is considered as a defining feature, but limited in its ability to encompass the whole nature of health visiting.

1.2 Knowledge creation in health visiting : science and experience

One of the definitions of epistemology includes ‘study of the source of nature and the limitations of knowledge’ (Collins 1992) and it is this which will be explored. An argument will be developed which suggests that health visitors have a limitation or partial knowledge about women’s issues. Exploration of knowledge creation will suggest this is due to an orientation formed by a scientific outlook and a taken-for-granted view. An alternative possibility through a feminist view of dynamic knowledge creation and appropriate use of experience will be proposed.

Research conducted with health visitor students showed them to operate through sex-role stereotypes and a patriarchal view of the world in which women were seen as somewhat dependent and exercising little control over their lives (Orr 1986). The assumption being that the health visitor students were, themselves, not part of this group of women. A view, which legitimately could be made on the basis that they were mature female students within Higher Education, following a new career pathway and therefore not ‘typical’ of women in general. In respect of the education of health visitors, Orr asserted ‘What they have is a male view of the world, masquerading as science’ (Orr 1986:75). She also identified that health care workers, including health visitors, were not sympathetic to the needs of women (Orr 1986; 1981). They have still appeared uncaring towards women and have been criticised for not recognising the needs of women subject to domestic violence, or

the needs faced by lone women parents (Peckover 1999; Knott and Latter 1999). These scholars reveal a common problem which has evidently not been addressed or received emphasis over a twenty year span in health visiting. This section raises issues about knowledge creation within the curriculum and what may be perceived through these examples, as inadequacies in the preparation of women to visit women as clients.

The comment by Orr, about health visitors having a 'male view of the world' and the relationship that this has with science suggests a limitation on the potential range of knowledge available. It is implied that more knowledge can be found, and a different view point must logically be considered as a 'female view of the world'. A challenge to the 'male view point', which was not available in the 1960s and much of the 1970s, has come through an alternative way of looking at science knowledge creation which has developed within feminist writings. Feminist scholars raised questions about the scientific-rational approach and the supremacy of objectivity and androcentric goals being seen as the key sources of influence (Harding 1987; Hawkesworth 1989). Different or 'better accounts of the world' are possible when women's view points receive a deliberate focus (Haraway 1988:581). The crux of the debate is that a different view or definition of objectivity is proposed, which is about location of knowledge and the possibility of knowledge being active. Haraway defines this in her statement 'I would like a doctrine of embodied objectivity that accommodates paradoxical and critical feminist science projects.

Feminist objectivity means quite simply *situated knowledges*. ' (Haraway 1988:581).

This contrasts with what has been termed transcendental knowledge - that which is without context and is considered known to all and as the dominant view. Situated knowledges thereby provide a rationale for contextualising knowledge and utilising experience as a source in feminist research and as a source for knowledge creation. This concept also contributes to a post modern platform in which a variety of meanings and discourses could be developed from one source.

Insights from women scholars show other new dimensions that began to emerge in the 1980s. 'My experiences as a mother and a professor are often contradictory. Women scientists often talk about the contradictions between what they experience as women and scientists' (Harding 1987:7). A similar view was expressed by Stacey as 'cross pressures' experienced by women workers, for example nurses, as women and workers, and by Smith D.(1987:6) as the 'fault line' between what women sociologists' experience as sociologists and as women. The startling interest in these statements, is that in a job where women could be identified as women in their working role, they appear to have created a bifurcation (Smith 1987:6), which separates their personal history of being a woman, from the service which they deliver to other women. A contradiction is that historically health visitors were recruited for their 'womanly qualities' (Davies C. 1988:57) rather than for their educational preparation.

Women's experience has been seen as a core concern in feminist research because of the previous exclusion or potential distortions of women's reality in traditional objective research (Blackmore 1999). In respect of health visiting there are some parallels with the research by Blackmore, who asserted the centrality of women's experience in feminist discourse and highlighted that the women in her study, who were women head teachers, were very uncertain about their own subjective experience being of value. It would appear that health visiting is highly orientated to a scientific outlook and that the place of experience and the nature of a woman's position and outlook is not utilised as a perspective. A crucial question from Blackmore, which is appropriate for health visitors, is within her argument against the male transcendental position of scientific objectivity, in which she juxtaposes the experience of the individual woman. She questions 'what is a truer account than the subject's own account?' (Blackmore 1999:65).

Experience is also central to feminist politics by its basis in social transformation and its ability to reveal subordination and strength, which have been traditional areas of research in feminism. The relationship of these is summed up in this statement by Lewis, 'Politizing the personal through the articulation of experience is supportive of this process' (Lewis 1993:5). The issue of undervaluing personal experience for women and its link with a feminist view of oppression is also expressed by Lewis as a result of her research in teaching.

By trivialising our experience as mundanely personal and hence insignificant, we live out our oppressions and subordination with eyes cast to the ground limiting the horizons of our own visions. (Lewis 1993:5)

Values in society about gender differentiation and women's work with caring and children are still considered to disadvantage women (Francis 1999) and this also has an influence upon women professionals' seeking to work as equal team members in many settings. It is argued that these societal values contribute to the downplaying by health visitors of their own personal and subjective experiences of family life and child rearing where this has occurred.

Discussion in this section has shown that health visitors are not alone in developing a 'malestream' way of viewing the world. However they may, more than others, because of their work, be in a position to draw together their scientific base and their personal and professional experiences in the creation of a different or alternative knowledge. Being seen as scientific has been of importance in health visiting, but the reality and contradictions of the position in which they find themselves, that is as women visiting other women, is considered in this thesis to have contributed to some of the difficulties of role definition.

2.0 INVISIBLE WITHIN VARIED DEFINITIONS

Introduction

Different ways of defining health visiting show some of the complexity of the work, this will be seen through the concepts of surveillance, relationship, resources and securing life trajectories. These have been offered as ways of categorising the work even though core activities and skills were not identified. There are three factors which arise regularly in respect of the definition of the role of health visiting. These are the monitoring efforts towards the infant achieving its full potential, health education which may be short or long term for all family members and maintaining a relationship in order to accomplish the work - the process. However, as will become clear from the discussion these are not mutually exclusive elements but different aspects of the whole. In addition, the diversity adds weight to the issue of confusion, lack of a key focus and a sense of elusiveness. Robinson identified that there have been few process measures for health visiting and provided a neat commentary on the home visiting aspect of health visiting, as the 'black box' which generally remains closed. Her summary description is that health visitors are 'engaged in predominantly primary preventive activities involving a broad range of health issues among diverse groups of individuals and families, many of whom are vulnerable in a variety of ways' (Robinson 1999a:17).

2.1 Child health surveillance

Health visiting as defined through the Audit Commission (1994) and by its history has participated in child health surveillance from a positive stance of monitoring and promoting the growth and development of children. Health visiting is part of the State provision of universal help to children through the child health surveillance programme which provides assessment of development, and a first visit for families with new babies (Audit Commission 1994).

It has also through this mechanism identified the lack of normal developmental processes in infants and children both as an outcome of disease and also of neglect and abuse by the carers. The focus on children as the main client has been currently reported (Chalmers 1990) and has appeared consistently to be so during the hundred year history (Smith J. 1996). Efforts to broaden the work to encompass the whole family were apparent with the changed curriculum in 1965, which sought to embrace the principles of the 1956 report 'An Inquiry into Health Visiting', the Jameson Report, in which encouragement was given to 'a general purpose family visitor', however almost forty years later the glossary from the Audit Commission shows that this was not realised in practice.

Health Visitors : Nurses (who usually have a midwifery training) who have undertaken a year's additional training to specialise with working in the community, with a broader public health /health promotion role. They nominally work with all client groups, although in practice the vast majority of their time is spent working with families who have children aged 0 to 5. (Glossary of Terms, Audit Commission 1994)

The definition is somewhat flawed in its comment about health visitors and a midwifery training; this makes reference to the legislation which made midwifery or an approved obstetric course obligatory for the new curriculum in 1965. This was repealed and the UKCC figures for practising health visitors shows that in 1995 there were 43.76% of health visitors holding a midwifery qualification and by 1999 this had fallen to 40.57% (UKCC 1995; 1999b)

2.2 Influencing health by relationship

A definition of health visiting, by Chalmers (1990), is more useful for this research, with its emphasis on interaction, but also with a relationship of service and person being made explicit

Health visiting is essentially a service provided in the context of the social world in which the health visitor interacts with people in an attempt to influence health. (Chalmers, 1990 :15)

The service described and analysed by Chalmers developed a theory of giving and receiving and included health visitors' work with children, with women, and with men. The brief discussion on work with women acknowledged the women's health movement but identified that the impact of influential writings was not generally reflected within health visitors' conceptual frameworks for working with women's needs and roles. A rather restricted and somewhat negative interaction with women was shown through Chalmers' research, mostly linked into parenting ability. However recognition by health visitors, of women through caregiver to multiple roles was reported, and some health visitors did approach assessment with the

multiple roles forming a construct for their visit. But the overall conclusion was that health visitors had no consensus in their way of managing women's life events,

The degree to which health visitors consider women's other needs or roles appears to influence how their services are received. For example, when women had lost relationships through death or desertion, some health visitors did not explore or acknowledge the meaning of these losses to the women but continued to focus their interventions on child health issues. (Chalmers 1990:216)

There is evidence here that women's needs and the ability to relate to these from a conscious construction of 'woman as client' are weak, and therefore are a necessary part of the continued development of the health visiting profession that should not be ignored. This fits with an analysis by Elkan et al (2000a) in which they placed the model developed by Chalmers within a traditional disease based approach to health visiting, with a 'public health' orientation - which by its very nature is scientific rational in its analysis of disease and disease prevention. The work by Chalmers was also seen within their framework which emphasised 'participation, control and empowerment of clients' (Elkan et al 2000a:1319) within a moderately radical and individual approach. The internalised model which has impact upon the way health visiting is carried out appears, here, to offer participation, but as an exchange based upon the same world view, in 'giving and receiving' (Chalmers 1992) without utilising a more equal relationship, in keeping with a feminist outlook.

A more equal relationship seen in a partnership model was developed by Barker (1992) in which health visitors received in-service education in how to relate to

clients in a non-directive way (Twinn 1993). This was recognisable by health visitor participants as a different way of developing health related activity within families. Although not utilising a feminist model, there appeared more empowerment of the woman in her role as carer of the infant. The strength was seen in not being driven only by medical issues, but by a philosophy of parent support, particularly with those in socially deprived areas.

2.3 Interpersonal and relationship work

Cowley (1995a) asserts that the early feminist dimension of health visiting became restricted during the developmental period of the 20th century, when health visiting became dominated by the Medical Officers of Health, but she does not build upon this from a gender perspective. Later, Davies C. (1997:110) argued that the three models which competed for the key development of health visiting were dominated by gender issues 'In each case, gender was the lens through which a meaning was given to the work'. Thus there have been threads throughout scholarly writings which attest to gendered issues having relevance to health visiting.

Of interest to this study is the discussion by Cowley (1995a) on personal and situational resources for promoting health. Health promotion is a sufficiently variable activity to encompass both these dimensions and Cowley utilised a theory of learning and the place of the expert practitioner, to position both of these resources

within a personal / professional model. This was of the individual operating holistically, knowledgeable about both dimensions and not relying on 'book learning' alone. Caring and its position in nursing or health visiting were not a key feature for Cowley's study, but she considered there to be a link between interpersonal activity and caring. This could be considered a token recognition for this area of investigation; as was the one reference to the gender-divided thinking in the NHS organisation and a brief comment on feminist methodology.

The definition and descriptions of health visiting provided by De la Cuesta (1992) show some of the tensions between the service and person aspect of the work. Health visiting is described by De la Cuesta, as being to secure life trajectories, which places it steadfastly within the policy of child health surveillance. This was confirmed through the data statements in outcomes for the work by health visitors with the carers of the infants and young children. From her research De la Cuesta identified a strong thread to do with the relationship in health visiting, and in particular that the relationships were said by health visitors to '...contextualize their work....were established to gain the client's co-operation, and that the ...work is dependant upon parental participation, and the relationship itself becomes a resource in health visiting work' These extracts show that the carer is not in the position of client in their own right, but nevertheless is in a crucial juxtaposition to health visiting work. At the same time, the evidence gives a highly personal aspect

to the work and shows a degree of flexibility, that 'is not a matter of delivering a predetermined service by anyone'. (De la Cuesta, 1992, 247-248, 252).

However, De la Cuesta, has by this analysis, implied that 'a service' is on offer as distinct from 'a relationship' and discusses the need to work with the client's agenda and world view in order to 'market the service'. This appears to place the carer in a partner or broker role rather than as a recipient of health visiting expertise and perpetuates the focus on the child or the mother/child unit, and gives no route for a changing emphasis upon the woman with her own needs *except in relation to the ultimate gain of health in the child*. One of my aims is to show how the health visitor herself can be a resource in a relationship with the woman carer, and in making personal the service required by national and local health policy. Thus the notion of a predetermined service, as the main way forward, will also be challenged, but from the perspective of the health visitor rather than the client as argued by De la Cuesta.

The concept of caring work and its invisibility was contextualized within social welfare through De la Cuesta's analysis of fringe work by health visitors. This, with her debate about emotional labour within the analysis on marketing and selling, provides a laudable account of health visiting, that the relationship for the health visitor is a means-to-an-end. It is also noted, by her, that emotional labour is rarely acknowledged in health visiting. Towards the end of her study, De la Cuesta brings

together the concepts of emotional labour and caring, linking them through Graham's (1983) seminal work on caring and by assumption that this is the reason that health visiting lacks acknowledgement of emotional labour and caring. Invisibility is portrayed here as inevitable and integral to health visiting.

Robinson (1986) in her doctoral thesis, reported the conversational forms of health visiting, and in doing so showed one element to be 'friend of the family' with a 'friendly type' of interaction, which has been linked by De la Cuesta (1992) to the management of feelings, selling themselves and giving a service. This, while being a true representation from Robinson's empirical study, did not pick up any aspect of relating which I perceived to be based upon a *real* exchange from woman to woman.

One of the issues which has become clear over a variety of studies is that health visitors and clients do not appear to relate in a personal exchange that is valued by both individuals. In a study which looked specifically at health visitor/client interaction sixteen health visitors were observed in action with home visits to children under one year of age and the interaction was audiotaped; this gave a total of sixty two interactions (Kendall 1991). Separate interviews with the health visitors and clients were conducted to gain their perceptions of the interaction. The findings showed that there were different perceptions between the clients and the health visitors regarding four key elements of the visit, namely the objectives, perceived

health needs, plan of action and follow up. However this was not apparent to the health visitors, who all seemed positive about the outcome of their concept of client participation. There was a similarity between the health visitors, who were from two health authorities, in the way they did not generally facilitate client participation.

Other studies have highlighted an advice giving exchange between health visitor and client which appears to reveal a further level of difficulty in the way in which health visitors relate, or do not relate adequately, with their clients (Sefi 1988; McIntosh, 1986). It is suggested here, that this is related to the scientific stance and the requirement to fulfil health policy related goals, with the health visitor providing a service and acting in the role as a 'vehicle of the state' in her activities (Dingwall et al 1988).

What is not shown is the caring and genuine interaction by health visitors when they draw from their own personal resources. The research, being reported in this study will show how emotional labour and caring can be a *real* activity, alongside this more distant and objective style of interaction. A belief underpinning this empirical study is that women health visitors do relate from their own inner resources in their relationships with women clients; or that they evidence tentative behaviour in this

direction but without a model to pursue this as a legitimate undertaking. It is suggested here, that this is more than a ‘professional stance’ of creating rapport and preparing the ground for whatever other work is needed, but is on a woman-to-woman basis.

3.0 NHS : HEALTH VISITING AND VISIBILITY

Introduction

The NHS has a mandate to account for ‘value for money’ and to provide services within the principles of clinical governance. The requirement of targets, contract agreements and measurement of work are identified in the next section as mechanisms which may assist the visibility of health visiting. A case is made that work with mothers has been constantly present in health visiting but not evidenced through a systematic and transparent way of acknowledging this aspect of the job. It is argued that the lack of ‘official’ recognition of this has contributed to the way in which health visitors have construed their work and that the metaphor of invisibility has given meaning to the work which was not seen separately from the work with infants and children (Mezirow 1990:xix). The mechanism of surveillance and increasing self monitoring through the ‘employer gaze’ is also discussed in relation to the Panopticon gaze and feminism.

3.1 Hidden work with mothers

McKee and O'Brien (1983:160) in their study on mothers, found that life issues such as loneliness, bereavement, illness, poverty, were at times far more important to the women than mothering in its narrow focus on the infant. The context of social and environmental dimensions needed speaking about and could not be disregarded in the dialogue which had as its focus the work of mothering and caring for the new-born. The importance of life events, alongside the new infant, were seen as demanding a high priority by the mothers as judged by the emphasis and time given to them as topics.

It is argued that health visitors have regularly engaged with these issues, but the NHS has not had a suitable mechanism within which to display this aspect of the work. The introduction of new technology with computerised recording systems has provided a vehicle so that the type and volume of work with adults can be easily quantified. This will reveal a hidden part of health visiting which has not previously been included within operational targets and estimates of staffing requirements. However, it is questioned whether the lack of recognising work with adults was a function of lack of recording systems, or whether there was no plan by the Department of Health to use this contact in a health related way and so recording systems were not developed. The assumption, therefore, is that health care to adults was seen by health visitors as opportunistic contact, but not valued through the

employing authority as part of the caseload with a time commitment attached. This has contributed to the invisible and hidden activity within health visiting.

This changed by two important features during the 1980s which gave more emphasis to the work with adults and which re-inforced the impact of the technological advances of computer recording, and will be considered in the next section .

3.2 Ways in which the NHS has promoted visibility

The introduction of targets to give direction in health care, drawing up contracts for purchasers' of services plus marketing techniques will be identified as ways in which the Department of Health has introduced a mechanism that could heighten health visitors' awareness of the more hidden parts of their activity. Progressive refinement of the computer data base for recording work is included as an NHS method of collecting detail on work accomplished, which should lead to a greater understanding of health visitors work. The increasing surveillance of their work in these ways will be examined through the Panopticon gaze as a means of increasing conformity to new ways of working. A feminist perspective on power relations, based in the work of Foucault, and related to NHS methodologies will bring this section to a close. Further detail on the Reforms in the NHS will be explored in the next chapter.

‘The Health of the Nation’ report (Great Britain, DoH 1992), for the first time, gave health care workers a national agenda for change. Health targets were now included in the language and work of health visitors. Although questions were raised about the philosophy underpinning the targets, about the ‘climate of blame’ for ‘self-induced’ health problems and about the time needed to fulfil the introduction of the targets, it was soon clear that ‘targets’ were to become part of the work role. Gradually this became identifiable with the Public Health part of health visiting and with it came a time allotment, generally regarded as 10% in the contracting system with the General Practitioners (DoH 1989). A new publication from the Labour government, *Saving Lives - Our Healthier Nation* (DoH 1999c) and Health Improvement Programmes continue with the emphasis on targeting for recognisable changes in health outcomes.

‘Value for Money’ was a catch phrase which impacted upon the accounting and auditing of all personnel in the NHS with requirements for more clarity about what work was undertaken and attempting to make transparent the use of time. This was embedded in the NHS Reforms of the Conservative administration, NHS and Community Care Act 1990 (DoH 1990). Purchaser - provider mechanisms were put in place through changes to the Health Authorities and thus financial considerations became a more prominent part of the management of staff. With the Reforms came the GP Fundholder system and contract agreements which would quantify the

workload of the health visitors who were working with GP fundholders but ‘purchased’ from a Health Authority provider (DoH 1989).

A further feature, which continued to point up the invisibility through lack of outcome measures and achievements in health visiting, was the Department of Health’s major marketing initiative to assist understanding of what was ‘on offer’ (DoH 1994, England). The lack of clarity was from both sides - the ‘sellers’ in the form of health visitors and health authorities needed help to know what to sell and general practitioners needed to know what they were ‘buying’. However the emphasis on outcome measures and evidence-based practice becomes problematic when a process of interpersonal links, seen by some experts, can be regarded as fundamental to the work but not valued or recorded (HVA 1995).

Through these initiatives and with the availability of data base recording systems, the work of all health care practitioners should be increasingly transparent. This can be seen as a surveillance mechanism put in place by employers in their role of becoming more accountable for the services provided.

3.3 Panopticon surveillance, power relations and Foucault

One way of analysing surveillance and power by ‘authorities’ has been through the Panopticon gaze, discussed as a disciplinary technology (Prado 1995; Dreyfus and

Rabinow 1982). The key to surveillance in the sense applied by Foucault came from the function of managing populations within institutions through devices - crucially based on recognition of a 'localised seat of authority' and the principle of 'panopticism' being applied. Panopticism, based upon the Panopticon form of prison, was offered by Foucault as a way of understanding the operation of power via the mechanisms of remote, unseen authority being exercised in such a way that the individual felt constantly under scrutiny. This is said to produce internal changes, with the individual monitoring their own behaviour against the new norm (Prado 1995; Dreyfus and Rabinow 1982).

There has been considerable debate over the contribution which can be drawn from Foucault to feminism, since he did not directly address women's issues in his discussion about power relations. Nevertheless, the work of Foucault is explored in feminist literature in different ways, for example, resistance and normalisation (Bordo 1993) and changes within the self (Birch 1998). The technique of surveillance and the disciplinary gaze are related to the concept of 'normalisation' which Ramazanoglu (1993 : 22) describes as an indication of 'the extension of control and self-regulation' developed through the surveillance process. Normalisation is the requirement for closing the gap between what the discourses have defined as normal and that which is outside of the 'norm'. The link with feminism suggested by Ramazanoglu is the way in which this process reveals social pressures on women, because they are women and not men. A similar view is that

health visitors appeared to conform to the social pressure for change in their work, but had not yet found a way of resisting in order to protect ‘women’s work in a man’s world’ (Davies C. 1997:110). It is argued that this points to a gendered service in which women as employees are within a binary system and seen as subordinate and conforming with female stereotypes.

4.0 HEALTH VISITING AND GENDER

Introduction

This final section focuses on concepts that tend to be hidden within the activity which links the health visitor with the client. The key issue is that health visitors are regularly reported to assert the importance of ‘the relationship’ but little evidence could be found to explain its importance to health visitors and women clients. A feminist perspective is examined in respect of emotional labour and caring, and relationship and connection in which health care activity and women’s inter-connections have been identified. The section concludes with a short discussion on paradoxes and dichotomies seen in models of health visiting through a problem or relationship approach, a public or private activity and the personal or professional self as a resource.

Only one recent research study could be found in health visiting which upheld the guiding principles for feminist research, as described by Siebold et al (1994), for women's experiences being the major object of the investigation, for the researcher attempting to see the world from the point of view of the woman, and for the researcher to be active in trying to improve the position of women. The study was conducted by Peckover (1998) who utilised a feminist poststructuralist analysis to reveal the practices between health visitors and women experiencing domestic violence. Her findings showed inadequate responses once the women had broken their silence and Peckover urged greater attention to developing health visitor's abilities in identifying and dealing with domestic violence. It is argued, as health visiting is conducted by 'women' and largely for women, that the lack of feminist insights into health visiting through research is a considerable deficit. With respect to the first statement by Siebold et al, although health visitors and their clients are usually women, they are seen within the empirical research as health care workers and clients, not ostensibly as revealing experiences of the female, whether worker or client. Secondly then it follows that the analyses are without a world view from a 'woman' perspective, and thirdly that while a client's position may be improved as a result of greater understanding about the interactions with the health visitor this is improvement for a 'client' and not a 'woman'.

4.1 Emotional labour and caring

The concepts and practice of emotional labour and caring will be considered as inter-related through the way in which they have been taken up and utilised in nursing; extrapolation into health visiting will be developed and links made where possible with health visiting literature. Hoschild (1983:7) made the case for emotional labour as being a 'planned' rapport and relationship, a form of required work - thus a labour, in which the outcome was for another person to experience feeling cared for - rather than as a reciprocal relationship. A case will be made for an extension of this definition as being an activity which takes place through interaction between women on a basis of shared experience rather than only as an extension of the work role of the health visitor. De la Cuesta (1992 : 251) put emotional labour in health visiting into the context of building trust as a necessary part of the work and also that it needed to be seen by the client as an attribute that was both personal and professional. This points to the activity of work as being both personal and professional which this study builds upon.

Pearson (1991), by contrast in her study of health visitors did not mention women or womanly qualities. However she gave examples of clients wanting health visitors to come and talk to them and give support with coping skills and social contact - the clients wanted someone to talk to - by assumption on a woman-to-woman basis but a response to the women by health visitors was not seen, nor was a rationale provided for this work. It will be argued that this is part of the hidden

work in health visiting, is emotional labour and is based upon a caring paradigm that receives legitimacy and a new, visible profile when viewed through a gender lens .

Graham (1983), produced her seminal work on caring, and provided an analysis which separated the theoretical model of an intrinsic female disposition to caring provided by psychology, from a functional model provided through a sociological or social policy analysis. This showed caring, from empirical studies, as a labour which ensured life, that could be seen as a ‘daily grind’, and contributed to the economy by its activity. However her conclusion was that caring ‘typically remains unseen and unspoken’ and although an essential activity ‘is invisible, devalued and privatised’ (Graham 1983:26,27). A distinction was made by Graham between informal caring, described through empirical studies, and formal caring found in the service-sector arena of nursing, teaching, social work, which she later broadened to include others, for example secretaries and cleaning staff.

In nursing, the concept of emotional labour was made accessible through James (1989) and her empirical study of hospice work. She defined emotional labour as ‘the labour involved in dealing with other peoples’ feelings, a core component of which is the regulation of emotions’. She described it as being ‘hard work and can be sorrowful and difficult’, bringing with it a specific requirement from the ‘labourer’ that is personal and individual to the situation. It appears to go beyond the planned emotion described by Hoschild.

It demands that the labourer gives personal attention which means they must give something of themselves, not just a formulaic response. Its value lies in its contribution to the social reproduction of labour power and the social relations of production, with the divide between home and work and the gender division of labour influencing the forms in which it is carried out. ...[It] is a form of skilled, regulatory labour which is carried out in the 'public' domain of the workplace as well as in the 'privacy' of home. (James 1989:19)

These assertions bring into view some of the tension in health visiting, the hard work of managing feelings, which is part of the job, takes a toll from the health visitor, but remains largely unrecorded. James discussed the exhausting nature of emotional labour, and the requirement for respite following sustained interaction of this kind of labour. The hard work and the lack of being seen is similarly noted by the Health Visitor Association (1995) in discussing health visiting as an interpersonal process.

The intervention and outcomes [in health visiting] may not be perceived as legitimate, either because they do not conform to managerial perception of health gain, or because they are not perceived as the result of hard work and skilled intervention, but an extension merely of what are commonly perceived as 'womanly qualities'. They are in consequence likely neither to be valued or recorded. HVA (1995: 29)

A highly significant comment by James (1989 : 31) was that 'the hidden component of the work does not stop it from being vital to the work'. This assertion has relevance to health visiting; it is argued that this invisible and hidden component to the job has remained a vital ingredient in the survival of work which is regularly criticised for its lack of clarity and visibility. This study seeks to reveal some of the hidden and valued work.

Questions of importance are whether emotional work in this definition will remain possible in the new modern NHS ; also how providing emotional labour could be upheld in health visiting with mounting pressure from the NHS for evidence - based practice and outcome measures. There is evidence of the health visiting workforce being reduced, and therefore the possibility of extending the role from young children to incorporate women and other family members might be reduced. In her study of student nurses (Smith P. 1992) argued that there was a relationship between emotional labour, connection and involvement which was linked with the concept of caring and seen within the context of gender and nursing qualities. This has been extended and confirmed in her recent report which includes findings about qualified nurses as well as students (Smith and Gray 2000), and thus remains an issue under debate.

In her study, Chalmers (1990:295) concluded that ‘most health visitors considered that they offered clients a professional service to individuals and families within a supportive caring context’. There is little expansion on what was meant by a caring context apart from the work of building relationships. However it is not dissimilar to the definition provided by Sevenhuijsen (1998:82) in which care is seen as an activity with its basis in “an ability and a willingness to ‘see’ and to ‘hear’ needs, and to take responsibility for these needs being met”. In the ‘caring professions’ this definition provides a route into a concept of care that is related both to a process

and a practice which has its roots within a feminist ethics of care and which could provide a model for practice. A typology of caring that shows four phases and related competencies and values, offers a means of relating care to a corporate/community activity (Fisher and Tronto 1990; Sevenhuijsen 1998). There is very little literature which links health visiting and feminism/gender and this study seeks to re-dress the balance by drawing on feminist debate about the ethic of care in relation to health visiting. It will also thereby identify hidden aspects of the health visitor's work in caring.

Skeggs (1997:67) in her research with women identified a 'conflation of skills and disposition' in the development of a 'caring self' - so that a caring personality and a definition of caring incorporated two different meanings.

Caring *about* which involves social dispositions that operate at a personal level and assume a relationship between the carer and the cared for, and caring *for* which involves the actual practice of caring, involving specific tasks such as lifting, cleaning and cooking and does not necessarily relate to caring about. (Skeggs 1997:67) (italics in original)

Another definition of caring, which incorporates commitment, is also useful in illuminating some of the interpersonal processes which operate in health visiting. This was developed by Davies C. (1995) in respect of caregiving, carework and professional care. Although directed more specifically at nursing, her context of a new view on professionalism and the potential she sees in the 'rationality of caring'

linked to policy, are entirely pertinent to health visiting within its broader setting of nursing.

Caring can mean just ‘being there’ for someone, not necessarily listening, not necessarily even being present but being known to be available, checking the situation out from time to time and being ready to respond if asked. Caring in this broad sense can be defined as *attending, physically, mentally and emotionally to the needs of another and giving a commitment to the nurturance, growth and healing of that other*. (Davies 1995:141) (italics in original)

The health visiting relationship is frequently conducted in discontinuities and with the understanding by both ‘parties’ that a response will be forthcoming if needed. Health visiting literature abounds with references to developing and maintaining a relationship with clients in order to promote their work (Cowley 1995; De la Cuesta 1994; Chalmers and Luker 1991). A difficulty is in identifying that a health visitor, in this analysis might be classed as a carer and the client as ‘the cared for’. This is not common practice in health visiting, but it is argued that the ‘relationship’ viewed in this way opens up a new perspective upon the process and practice of health visiting.

A further dimension of relationship to be examined is that within the concepts of connection and relationality. A feminist theory of women’s development makes a link between relationship and the proposition that women engage in making networks and connections. This assertion lays a foundation for the possibility of health visitors seeking to maintain ongoing relationships with clients as a part

fulfilment of being women engaged in working patterns that allow for a wide range of interpretation and activity.

Women seek to build connections. They seek to maintain connections that have been built. Relationships are more than a set of interactions among people. They are the web of existence. (Shrewsbury 1998:169)

No very satisfactory rationale has been provided for the strength of comment by health visitors about the 'relationship'. However, in feminist literature, gender differences in orientation are proposed by various writers, with women focusing on relationship and connection, while men focus more on the self and on separateness (Ferguson 1988; Gilligan 1998). Interpersonal skills and competence receive limited attention in health visitor education or health visiting research (Chalmers 1990; De la Cuesta 1992). In the current context of quantification of work a question raised here is whether or not the 'relationship' is in reality an essential part of the work? This was raised as a question by Luker (1982), who asserted that a professional relationship was already present because of the professional role. Could the 'relationship' be a 'luxury' and a self imposed part of the job which health visitors have held onto during the decades of limited monitoring and a somewhat artisan approach to the job? Or is the explanation for the emphasis based within the gender view of connection and relatedness?

4.2 Dichotomies and binaries

Two different dichotomies have been regularly discussed in the health visiting literature. One to do with a clinical model of problem solving or a social work model of developing relationships (Clark 1985; Robinson 1982), the second to do with ‘family friend’ or ‘professional worker’ (Clark 1985; The Jameson Report 1956;). However, Chalmers (1990), concluded from her data that both elements were included in health visiting - both the service needed and the support needed - and therefore they were not operating from an either/or position and therefore this was not a dichotomous model.

Alternative terminology of a paradoxical status of worker/friend was provided by Davies C. (1988) in a policy analysis of the origins of health visiting and the juxtaposition of men and women needed in the public health and sanitary work. How to be ‘friendly’ and at the same time provide a ‘service’ and surveillance was a root issue in health visiting. To some extent it is still an issue in current work with child health surveillance and child abuse identification.

It has been suggested that interaction with the parent/carer has been seen as a vehicle to attain access to the child (Chalmers 1992; De la Cuesta 1994) rather than to provide clearly specified health care to adult family members. However it is argued that the lack of recognition of the adult client group is linked to women’s work, especially within the home, and that it is part of the invisible phenomenon

noted above. The public and private dichotomy for workers can also be seen as part of the binary system which places women in the 'narrowing local sphere' of the home, with men in the 'enlarging terrain' of the public world (Smith D.1987:5). A key issue has been that a gender analysis places the subordinate worker in the private place, less visible, or the intermediate place in which the 'messy' or less technical - less visible - work is accomplished before the more visible worker - often in more technical, quantitative work - plays their part (Smith D.1987; Mayall 1993). Frequently this has been seen as a female / male separation in duties. Throughout the research being documented in this thesis there was a steady recognition that the more visible, technical work, was thought by the health visitors to be more highly valued by employers than less measurable work. Also, this was in preference to that which relied on long term educational input for changes or which sought to support and give care where there was emotional need.

Finally, in evaluation educational research the personal and the professional, both a binary and a dichotomy, have been seen as inter-related through research into changed perspectives. A major theme emerged of 'the importance of reducing the personal-professional schism, the desirability of living an integrated life and being an integrated self' (Patton 1990:454). Also in the educational literature, Jarvis (1992) discussed issues around the inter-relationship of adult learning and individual development. He shows complexities and paradoxes in lifelong learning and makes applications for those who work with people to recognise the paradoxical nature of

learning which draws on life experience. A further example on the complex interplay of personal and professional experiences comes from Eraut (1994). He discusses work based learning and perceptions and makes the statement that learning from experience 'depends on what is perceived, itself dependent on perceptual/cognitive frameworks and expectations' (1994:13). He appears to anticipate that individuals who are self aware will be more discerning about lifelong educational requirements.

It is traditional in health visiting to discount personal experience as relevant to the work, for example being experienced as a mother in child care, therefore being male or female is not considered an issue in the delivery of a 'service'. Rolls (1992) developed the debate on bifurcated consciousness and raised questions in respect of the supposed split between the way in which health visitor education tends to separate health visitors from seeing women's issues and yet these same health visitors are meeting in their own lives many of the issues that are present in the client population (Rolls 1992). Others have also made distinction between private and personal and the difficulties this can pose for the researcher and the 'researched'. (Lewis 1993; Edwards and Ribbens 1998; Mauthner 1998; Miller 1998).

Conclusion

The basis for the research questions have been explored, showing the extent and variation of view which has contributed to the reality of hidden practice. The way this might influence professional socialisation into views of being a ‘nebulous’ profession and incorporating ‘invisible’ practice have also been brought into focus through the metaphor of invisible. The need to value personal and professional experiences as legitimate resources has been highlighted through a feminist reading of science and knowledge. The role of the NHS in making professional practice more visible through recording systems has been noted. However the possibility of resisting this was raised through positive and negative features of Panopticon surveillance and introduced the possibility of a political view of NHS-employee relationships where women are subordinate. The need to explore and provide explanation for the ‘relationship’ in health visiting was seen through discussion on gender and dichotomies.

The conceptual framework for the research design was developed with these key dimensions and theoretical bases to inform the methodology. Additionally the pressures on health visitors from the National Health Service and nursing education also contributed to the preparation of the research and these are considered in the next chapter. This research will show some of the contradictions and issues displayed by health visitors as they utilise their own experiences, both personal and professional in the goal of giving a ‘professional service’. There appears to be a lack

of knowledge on how the health visitor uses herself as a resource through her personal and professional development. More knowledge about this may contribute to an understanding of how one group of women workers could develop and learn to focus on women as women and not 'neutral' as non-gendered clients. Secondly, to show how the personal and subjective interaction with women clients is congruent with a feminist model of human nature, and how the lack of emphasis on this aspect of the work may have contributed to the undervaluing of health visiting.

CHAPTER THREE

NATIONAL PRESSURES ON HEALTH VISITING

Introduction

As this study was conducted during a time of enormous change in the health service and also in the education of nurses, midwives and health visitors, it is important to explore some of the issues that impacted upon health visiting during that period. The study was at a particular time in this history when the Conservative administration had introduced NHS reforms which were being implemented from 1989 onwards.. Data collection was completed during the transition period for the reforms and in the period in which the new labour government was elected but before the Labour modernising NHS developments had been issued. This chapter will explore the events which were associated with the NHS reforms and the parallel events in nurse education. It will examine health visiting within the context of nursing and its new title of public health nursing - health visiting and will conclude with an exploration of gender issues in respect of nursing and the pressures discussed in the chapter. The chapter will offer brief commentary as necessary on the changes which have affected health visiting since the 1997 election of a new administration, but as these occurred after data collection will address them more formally in the concluding chapter.

Health visiting, never clearly defined within the health service nor fully accepted by the nursing world, and seen as marginalised by Hart (1994) has withstood pressures and gained ground during what has been described as the ‘greatest overhaul of the healthcare system since the beginning of the NHS’ (Webster 1998:5). The overhaul referred to was the changes put into operation through the 1989 White Paper, *Working for Patients*, followed by the 1990 NHS and Community Care Act. The data for the study were collected during the period of implementation of the market reforms, which these documents introduced, and their impact was evident upon the health visitors who were participants in the study. During the same period of time there were similarly far reaching reforms in the education of nurses, midwives and health visitors. The phased introduction of Project 2000 from 1988 for initial nurse education was followed by the Post-registration Educational Proposals, PREP, from 1995 for ongoing registration and post qualifying education. These have both had an impact upon the educational preparation of health visitors (UKCC 1986; 1998).

There was little direct interaction of these two pressures, evidenced by the lack of detailed knowledge held by the NHS about nursing education costs and manpower needs when it was faced with the introduction of Project 2000 (Davies C. 1995). This chapter will show how the two sets of pressure have come closer together through the ‘modernising’ strategies of the Labour administration which came into place in 1997/1998. Some contradictory issues will also be explored in respect of

tensions within health visiting in which the medical model, targeted public health work and disease prevention appear to be supported by the NHS, which leaves an uncertain place for health visiting based more in a social model of health with universal and generalist work at its centre (Elkan et al 2000a).

1 NHS PRESSURES

1.1 NHS Reforms 1989 - 1997 including General Practice Fundholding

During the third term of office by the Conservative Government, 1987 - 1992, there was a full review of the health service, led by Margaret Thatcher the Prime Minister, which had far reaching consequences for the whole of the NHS, including health visiting. The data, in chapter seven, will show the perceptions of health visitors who were affected by structural changes through the reforms and who were experiencing managerial surveillance in new ways. A Secretary of State for Health was created at this time, by dividing the Health and Social Security Office. Kenneth Clarke was the first to hold this new office, his appointment signalled a clear intention by government to give an undivided focus to the needs of the NHS in all its dimensions. The reforms arose from the issues set out in the 'Working for Patients' White Paper (1989) and became known as the 'internal market', in which there was a separation between the Purchaser of Services and the Providers of Services which allowed for a

competitive forum and engaged the providers of services in a kind of market. Hospital and Community Services could opt out of being part of a District Health Authority and could form NHS Trusts with independent status. General Practitioner partnerships could become fundholders and as such became new purchasers. For the first time in the NHS it gave general practitioners opportunity to control their budget for purchases to do with hospital services of surgery and pathology and also community care (Webster 1998; Davies C. 1995). Health visiting became a 'commodity' which could be bought and sold. The newly formed District Health Authority NHS Trusts, and General Practitioner Fundholders were required to commission and purchase health care for their local residents and patients (DoH 1989).

The work of general practitioners and health visitors became more deeply integrated through the Reforms. Four main areas of work were identified for general practitioners: the care of acute illness, the management of chronic disease, organisational matters (including computerisation and practice efficiency) and health promotion (Rivett 1998; DoH 1990). Health promotion, traditionally included in health visiting was seen to be a new and demanding aspect of general practice. A demand by the general public in accessing preventive health care, showed that consultations for contraception, immunisation and screening at 33% had overtaken the traditional main consultation source of respiratory disease at 31%, during the year September 1991-August 1992 (Ehbrahim 1995). The Government had set

targets and financial incentives towards health promotion issues such as immunisation and cervical cancer screening and towards clinical practice such as the assessment of people over 75 years of age, and is reflected in the figures for consultation. The pressure by Government for health promotion activity was sustained and change was achieved by introducing health promotion as part of the new contract for general practitioners.

Health promotion was seen as difficult and as unsuitable for general practice 'It was hard to convert the rhetoric of health promotion into contractual language or guidance to GPs about what they should do' (Rivett 1998: 412). But its impact became important in further evaluation of the work of nurses and health visitors in general practice. In respect of the employment of practice nurses, these numbers rose from 2000 in 1984 to 9000 in 1994, and they undertook health promotion work as well as developing clinical/medical work. Secondly, there were said to be insufficient health visitors to undertake all the required health promotion, but also there appeared to be restrictions placed upon them '... their employers restricted the work they did, and mothers and children came first.' (Rivett 1998: 414). Thus producing a view that health visitors were both unavailable in sufficient numbers and circumscribed in their work by employing authorities. This replicates a situation which occurred in the 1970s when district nurses were said to be 'home nurses' and therefore could not work the hours in general practitioner surgeries which were

required for the new work following early hospital discharges. This had also resulted in practice nurses being employed in larger numbers at that time.

Tensions can be seen here by Rivett naming the underpinning philosophy in health promotion as ‘rhetoric’ and the recognition that it was difficult to identify in quantitative, measurable terms for work purposes where that work, in this instance general practice, did not have a primary function in health promotion. This has been part of the ongoing difficulty for health visiting. Although health promotion has been a primary function, nevertheless the argument about difficulty in measurement does apply, and shows a way in which the metaphor of invisibility has operated for health visitors through their work in the public arena.

The ‘invisible’ nature of health visiting was of such concern to the Department of Health during the implementation of the reforms and the general practitioner contract in particular, that the unique marketing package, noted in the previous chapters, was produced by the NHS Management Executive. This was to assist in marketing the services of health visitors to their purchasers, both General Practitioners and District Health Purchasers. The project was developed with health visitors in a workshop format, that examined the kinds of work which could be marketed, practical marketing strategies and a questionnaire to elicit views of purchasers (DoH, England 1994). With so little knowledge about the effectiveness of health visiting it is surprising that the service was kept in this way and yet it

continues to receive support from the Department of Health. In 1999, within two years of the new labour government the Department of Health had given financial support for a simulation exercise into how health visiting might develop within the future of the Government's modernisation agenda (News item, Community Practitioner 1999; Office for Public Management 2000). The Office for Public Management was established in 1989 to carry out constancy with public sector organisations and to develop theory and practice as appropriate to achieve social results (Davies C.1995). It can be seen that both the previous and the current government administrations have taken steps to ensure an active place for health visiting within the NHS. Therefore a 'public invisibility' was recognised by government, through more than one administration, and steps taken to increase the visibility levels.

1.2 Health Promotion Work : targets for the NHS, raising visibility

The explicit demand through the General Practitioner Contract 1990 for health promotion and in particular for targeting immunisation levels, intersected directly with health visiting work which had traditionally sought to raise immunisation awareness with parents. As the new GP Contract came into operation there was a contraction of child health services through the 'clinic system' which offered immunisation via the Clinical Medical Officer. General practitioners were also increasingly undertaking child health surveillance assessments instead of infants and

children attending the child health centre; they also received extra payment if they were accredited as a practitioner in this field. A further intersection occurred in the distinction between 'health promotion' and 'public health' as the central feature of a number of activities involving general practitioners and health visitors. This had relevance to the way in which health visitors were subsequently contracted to fundholding general practitioners, with 10% of their work remaining with the service provider for 'public health' work

The first set of targets in Britain, for improving the public health, were set out in the document, *The Health of the Nation* (Great Britain, DoH, 1992). A disease-based structure formed the basis of the targets and five key areas were selected on the basis that it was known that intervention could reduce their morbidity and mortality (Rivett 1998). The targets were set for coronary heart disease and stroke; cancers; mental health; HIV/AIDS and sexual health; and accident reduction, all in a timescale from 1992 - 2000. Health visitors were actively involved in achieving these targets by their advice on dietary links with health, promotion of screening for cervical and breast cancers and the on-going work of reduction in childhood accidents. A priority for 'achieving Health of the Nation public health targets' was set by the annual NHS Executive guidance and was to be continued until they were superseded by the targets set in *Saving Lives : Our Healthier Nation* (DoH 1999a) by the Labour government (Morgan 1998:164). The Health of the Nation was applied to all aspects of health care, including midwifery where it caused a re-

examination of both antenatal and postnatal care in terms of dietary and other health promotion advice (Warwick 1998: 211) this has an overlap with health visiting practice; and it was supported in its aims and detail by a report on health conditions among ethnic minority people (DoH 1993).

Health visitors, in common with other workers, became part of the strategy for achieving specified health targets. This was an adjunct to the work of child health surveillance already in place and which became more closely tied to government targets through the Hall Report (1991, 1996) which recommended surveillance schedules to the Department of Health. These more visible targets, although long term and not easily measurable, give an indication of movement and change about the nature of work in the NHS. They also show a new emphasis on achieving external signs of health care activity. This was subsequently re-affirmed through the introduction of Primary Care Groups under the Labour administration, where local commissioning was introduced in the context of local targets and health improvement programmes (Webster 1998; Merry and Pearson 1998).

The lack of a common terminology in respect of 'public health' and 'health promotion' becomes important when evaluating the role of the health visitor in respect of the underlying philosophies and models of practice with which each of those dimensions is associated. Public health leans towards a medical model of intervention in disease processes, whereas health promotion seeks to incorporate

social and political factors into facilitating better health (Kemmm and Close 1995). The underlying tensions here, are also translated into different models of health visiting, with wide variation across biological, community and more individual approaches being practised (Elkan et al 2000a). The public health debate has increased focus on the measurable aspects of work, whereas the data had a focus in the process and less measurable aspects of the work.

The next section shows how pressures from nursing and nurse education have endeavoured to incorporate health visiting more closely within nursing; particularly at the time in which vast and overarching developments took place in the whole of nursing, midwifery and health visiting. This included a change of name to embrace ‘public health nursing’; however it will be seen that the changes have revealed tensions and a slight sense of elusiveness of health visiting within the new structures.

2 PRESSURES FROM NURSING

2.1 The relationship between nursing and health visiting

‘The process by which health visiting was captured as a branch of nursing is not well understood.’ (Dingwall et al 1988:188). This important and provocative statement sums up a continuing debate about the relationship between health visiting and

nursing. They have been seen as interdependent, almost since the inception of health visiting, but this relationship has been regularly questioned and challenged since the Jameson Inquiry of 1956, and most recently in the form of a public debate (Haughey and Cowley 2000). In the early development of health visiting the working relationship was with sanitary inspectors rather than nursing, although nurses were actively recruited from the early twentieth century. Historically, compared with nurses, there was also a salary differential and better conditions of service for health visitors. There was a full recognition by the state and by the Medical Officers of Health that health visiting was of significant value in the surveillance of health and illness and was part of the drive to manage maternity and child welfare (Dingwall et al 1988; Davies C. 1997). However, from 1962 a nurse qualification became a pre-requisite for health visitor education and a midwifery or later an obstetric qualification became a requirement. Thus linking health visiting ever closer to the governing bodies of nursing and midwifery.

Within this account an understanding of the relationship with nursing is important because changes within nurse education became an additional set of pressures for the educational development of health visitors. There were changes from within the internal regulatory bodies for nursing, midwifery and health visiting at the same time as the NHS Reforms exerted their external pressure to the practice of nursing, midwifery and health visiting.

In modern history the most significant legislative change in which health visiting 'was captured' by nursing was the 1979 Nurses, Midwives and Health Visitors Act. This legislation was designed to rationalise and simplify the arrangements for basic and post-registration qualifications in nursing, midwifery and health visiting, bringing together nine different regulatory bodies and the four countries in the United Kingdom. It should have facilitated an easy transparency for health visiting among the other groups. However the preparation for the Act revealed deep divisions of outlook between elements that were being brought into one framework and aroused anxieties that these differences would not be sustainable through the unified framework (Davies C. 1995; Batley 1983).

Health visiting had acknowledged previously the philosophy of the disease based curriculum of nursing and had introduced a comprehensive curriculum which facilitated a paradigm shift towards health and public health for intending health visitors (CETHV 1965; Davies C. 1995; UKSC 1998). In the 1965 curriculum equal attention to four academic disciplines plus health visiting theory and practice had been introduced. The four areas of scientific study were psychology, sociology, social policy and epidemiology, known as social aspects of health and disease. In addition, health visiting was practised in a systematic way of assessment, intervention and evaluation. In each area of study and practice the scientific approach was extended within the curriculum and produced workers who could analyse family situations from an objective perspective, utilising the scientific

concepts that had been developed during the education and training. This curriculum was in place for almost thirty years until the nursing reforms came into place. The proposed 1979 Act made possible future closer alliance between nursing and health visiting; there were concerns about the influence which Schools of Nursing might exercise on health visitor education as a result of the new Act which was to bring together the regulatory bodies into one place.

The fragility of health visiting, rather than its tenacity, was seen at this time. In fact, the education and training of health visitors was seen to be ‘in a perilous position’ by Batley (1983:97), Director of Council, Council for the Education and Training of Health Visitors. She also had the foresight to see the future assimilation of health visitor education within Schools of Nursing and Midwifery, although this did not actually happen until much later. It began to take place in the late 1990s, rather than the 1980s, following the incorporation of Schools/Colleges of Nursing and Midwifery within Institutions of Higher Education which was part of the Project 2000 reforms. Health visitor education had been regulated by the Royal Society of Health since its statutory recognition in 1946 with the National Health Service Act (Roberts et al 1960) and then by the Council for the Education and Training of Health Visitors who had oversight as courses moved into Higher Education Institutions. Batley’s view was that the 1979 Act, could lead to ‘a slow process of decline’ in health visiting with it eventually being phased out, but she believed that ‘...Parliament might have had something to say about that’ (Batley 1983:97). In

this statement she revealed that there was at that time a close relationship between health visiting and the state. This close relationship has already been identified as continuing into the 1990s and through two different government administrations.

2.2 Project 2000

The 1979 Nurses Act paved the way for reforms in the pre-registration (basic education) of nurses, which subsequently had an impact upon post-registration education, the category in which health visitor education was placed. The first reform in nurse education, following the Act, was the development of Project 2000 for the initial nursing qualification (UKCC 1986). The new educational programmes consisted of a common foundation programme followed by a specialist 'branch' in one of four nursing routes: adult nursing, child health nursing, mental health nursing and learning disability nursing. The new programme, being based in Higher Education and offering an award at Diploma of Higher Education level, raised questions about the role of the nurse who was more academic but also more comprehensively prepared for a particular aspect of nursing.

The impact on health visitor education was partly caused by the new pre-registration qualification being at the academic level of Diploma, this put pressure on post qualifying courses to be at an academic level of a bachelor degree. At the same time, the curriculum content of the new diploma courses had more emphasis on

health and more on community work, and less on disease processes, so that the curriculum content for health visitor education needed revision, and could be reduced in length because the foundation studies of health work had been introduced.

A crucial development with the new pre-registration education for nurses, Project 2000, was that it responded to earlier recommendations for the separation of the education of nurses from the NHS and service requirements and the need to locate the courses within Higher Education (RCN 1985; UKCC 1986). Nurse education in the UK was reported to be one of the last in the major English-speaking countries to separate from the apprenticeship system within hospitals and to link with educational systems (Rivett 1998). It was also noted by Rivett, that through the committee structures the leadership for nurse education moved from practising nurses and doctors to educationalists and those aware of community issues. This was evident in all the proposals for structure and content of the new courses. The incorporation of the Colleges of Nursing into Higher Education and Project 2000 Diploma Courses, was a phased process. It was competitive through a tendering process organised by Regional Health Authorities and Higher Institutions had to submit to the process of bidding for this work. The location of courses from Colleges of Nursing and Midwifery to Higher Education was seen by Ranade (1997:35) as 'the privileging of academic, educational needs over service needs' and this is still a controversial issue in the early 21st century.

The educational reforms maintained their title of 'Project 2000' in ways which led the COHSE Trade Union,(Confederation of Health Service Employees) to consider that this was still a 'project' which could be withdrawn in the future (Davies C. 1995). This perceptive comment finds some evidence in the Peach Report, Fitness for Practice (UKCC 1999a) in which much closer links with the NHS were again required, and furthermore were now extended into post-qualifying courses including health visiting. The issues discussed in this section, particularly the changes in level of awards, were discussed widely during the period of time covered by the thesis. The relevance of this was seen in the demographic details of the health visitors participating in the research. Many of them already had a degree in a relevant discipline or were currently enrolled on a degree programme. Some of them were community education practitioners and had students who were being educated to degree level for their health visitor qualification in 'Public Health Nursing - Health Visiting'.

2.3 Post-registration Education and Practice

After the implementation of the Project 2000, the second reform developed by the UKCC was a project to examine the needs of qualified nurses, midwives and health visitors, this culminated in the post-registration education and practice (PREP) requirements. These had an impact upon a live register of practitioners' through the

requirement of a notification to practice every three years with a declaration of the intended area of practice, study activity equivalent to five days in each three year period and the maintenance of a personal professional profile. A stipulation on a return to practice programme was also introduced, as were new requirements for programmes of specialist education. All practitioners were issued with a document describing the requirements (UKCC 1997). The PREP requirements for maintaining registration has been recognised as a new system of continuing education and lifelong learning, with each individual responsible for their own development and seen as a positive move, although there were questions about the role of employers in the management of the required study activity (Rivett 1998; Jenkins 1998; Hart 1994).

For health visitors there were questions as to whether or not they needed to maintain their nursing register qualification as well as their health visiting register qualification. A definitive answer was not given by UKCC in its examples in the document which was issued; it stated that this was an individual decision and that the study activity could reflect and update more than one qualification (UKCC 1997). This appeared to blur the issue about the core curriculum and work requirements for the health visitor and the need for nursing as a pre-requisite. This became important at 31st August, 2000 when new legislation allowed registered midwives who had followed the three year midwifery education, that is non-nurses, to register as health visitors. It would appear that legislation has, in effect, removed

nursing as a pre-requisite, however it is too early for any repercussions to be included in this account. Within these changes it is accepted that there was pressure for all the community practitioners and while recognising that health visiting was not alone in being subject to change, there were particular pressures exerted to bring health visiting under a clear framework that linked it with nursing in a more visible way.

The PREP requirements clarified the title of specialist practitioner and introduced new requirements for programmes leading to a specialist qualification which had to be at a minimum of degree level. As part of this project there were consultations about the preparation for community specialist practice and a decision to place health visiting in the 'broad family of community nursing', with eight specialisms was agreed in 1994. Debate about the issue of direct entry to health visiting, whereby the pre-requisite to be a nurse was also re-visited at that time (RCN 1998). A framework to meet acute care needs and community care needs was proposed for post-registration nurses, with the curriculum based on four broad areas: clinical practice; care and programme management; clinical practice development and clinical practice leadership; a common core was established, which had been proposed for community practitioners by the Cumberlege Report (DHSS 1986). Legislation was in place from April 1995 and new programmes phased in from then; a compulsory year for implementation was set for October 1998. Focused preparation for health visiting had disappeared and in its place was a set of core

modules with other specialist community practitioners. Hardly auspicious for a group of practitioners who were still wrestling with identifying their own core work in a changing practice climate.

In this way, one might say that nursing had finally captured health visiting within the standards for the eight specialist community nursing education and practice courses. Health visiting was no longer the title, but was prefixed by ‘public health nursing’ thus bringing conformity of nomenclature within the title and in the rubric of the document through reference to ‘The nurse...’ and in the framework of ‘clinical nursing practice’ (UKCC 1998). To complete the incorporation of health visiting into the philosophy of post-registration nursing it was proposed that the registerable qualification of health visitor be changed to a recordable specialist qualification in keeping with other specialist practitioners (JM Consulting Ltd 1998).

2.4 Health visiting - another form of nursing?

During what became the transitional period between the Conservative and Labour administrations, the four UK health departments had commissioned JM Consulting Ltd to conduct a review of the regulation of nurses, midwives and health visitors which it was anticipated would lead to a new Act and changed arrangements to regulate these professions. An extensive consultation exercise was undertaken on the findings of the review of the Nurses, Midwives and Health Visitors Act 1997,

with the acknowledgement that this raised complex issues. The questions seen as most significant were raised in the consultation document to guide respondents, both individual and from organisations. For health visiting, the review was quite clear that health visitors should be recognised as nurses and that it had been an 'historical anomaly to refer to health visitors as if they were a separate profession every time nurses and midwives are mentioned' (JM Consulting 1998:6). Their view was that health visitors had a separate register because they, alone in the nursing profession for many years, had a post-registration qualification. This singularity had now been overtaken by other specialist nursing groups having post-registration qualifications and therefore, by implication, was an out dated requirement. Thus their argument located health visiting firmly within the body of nursing.

The proportion of registered practitioners was a factor in the proposals by JM Consulting Ltd. Nurse registrations greatly outnumbered the other two groups and were in the order of 570,000 in 1997, midwives at about 92,000 and health visitors at about 25,000. Thus health visitors as a small group and getting smaller - the uncertainty about the future of health visiting and the lack of clarity about their work had inevitably influenced the recruitment and establishment numbers of health visitors. The 1999 figures for registration showed 752 new entries to the register, all of whom held at least the first level general nurse qualification. By comparison, midwives showed 3,600 entries without another qualification; although only

representing 0.86% of the total number of midwives, this was a new phase in the development of 'midwife only' education, that is by direct entry without the prerequisite of being a registered nurse. There was a drop in total number of health visitors, from 25,349 to 25,275, so that new entries were not providing replacement numbers (UKCC 1999b).

The pressure to drop health visiting as a registerable qualification did not find favour in the consultation exercise, the respondents held more firmly to the view that as a matter of public protection, in what was essentially a new type and form of work, health visitors should continue to be subject to statutory registration and be seen as a separate profession. This was supported by the labour government response to the review which made specific reference to health visitors and to their registration 'We have recently emphasised the important role and contribution of health visitors to a number of government policies, including the public health strategy, and we intend to maintain their independent representation'. The review position that health visitors should be referred to as nurses, and not be separately identified, did nevertheless find expression in the new title 'Nursing and Midwifery Council'. However, the government response rejected the view that the contraction of the title of the Act to omit 'health visiting' meant that there would not be separate representation on the Council, but proposed that there would be equal representation of nurses, midwives and health visitors from each of the four countries, (Allen 1999:39-40).

Maintenance of an identifiable health visiting service is seen in this recent government support and continues the recognition documented earlier in the chapter. It supports the comment that is voiced by a number of authors that the history and practice of health visiting is inextricably bound up with the state (Dingwall et al 1988; Batley 1983; Davies C. 1988). It has been seen as marginalised from nursing by its lack of an unsavoury 'past public image' and separation from the 'dominant ideology of health care' (Hart 1994:26). Although correctly identifying 'its origins in a different part of the public service from nursing and is essentially concerned with public health and with the care of young children.' JM Consulting Ltd (1998) did not see within this the philosophical underpinnings that contribute to it being a service that is different in its 'fitness for purpose' from the other specialist practitioners. Health visiting is about 'work in a primary preventive role with the well public ... an outreach service which is not dictated by the clinical nursing focus (UKSC 1998). Whether or not health visiting will continue to be more deeply incorporated into nursing, with further loss of its visible title is not yet clear. An alternative possibility is that it follows the example of midwifery and moves to 'direct entry' without nursing as a background. Implications of this will be considered in the concluding chapter, but it would facilitate a more radical consideration of the core work and the curriculum underpinnings, which this research would applaud.

There has been steady pressure over a number of years from within health visiting to return to its roots in public health as a means of clarifying its core work and focusing on the social and environmental needs of families and communities. The difficulty with this is to define and place public health work in such a way that it accords with the general interpretation of public health and supports a modern view of what this is about, is able to incorporate the philosophy of health promotion and takes account of the gendered view which prevails in these arguments.

For the participants in the study there was an issue about the public health content of their work, since it was 'ring fenced' at 10% of the work which was contracted with general practice fundholders (DoH 1989). The emergence of public health as a necessary part of the job was therefore present in a formal quantifiable way at the time of the study (SNMAC 1994; Audit Commission 1994). Further development of public health and health visiting has taken place with the new Labour administration from 1997. This has consolidated the trend that was evident in both NHS documents as well as the UKCC specialist community nursing education documents (DoH 1989; DoH 1990; UKCC 1998). Thus there has been both internal and external pressure to incorporate public health work as a more visible aspect of health visiting. The increased emphasis on public health has been reinforced by the Labour government in 1997, by appointing the first Minister for Public Health, Tessa Jowell.

The Audit Commission glossary (1994) identified a public health function, in its audit for children in need, by stating that ‘In this context the responsibility of community health staff, such as health visitors, to retain an oversight of the health needs of the community as a whole (e.g. accident rates, prevalence of health damaging lifestyles)’, was part of the work activity. There was no definition or hint of health promotion, but community profiles were identified for the assessment of health needs through health status, mortality, health risks and services available; surveillance with its opportunities for discussion of broader health issues was noted. An assumption here is that health visiting has a focus on the ‘community as client’ and that this, with the provision of an unsolicited service, is a demonstration of health visiting being a new area of practice, with a new body of knowledge that is not nursing (UKSC 1998) but is public health.

The potential for more visibility through an identified public health role and function can be seen as a direction for the future. However, the argument about public health as ‘health visiting’ remains a source of tension, with its roots in epidemiology, disease and medical issues and a community orientation. However, if social issues such as domestic violence were incorporated into the new public health model, there would still be the opportunity to retain the more individual model of work, rather than a re-focus to community, which had become a feature of modern health visiting.

Before completion of this chapter the pressures exerted in respect of feminist understandings on nursing and teamwork need to be considered. They show insights about the gendered nature of the NHS and the prevailing views exerted on nurses and nursing from this perspective. Recognition is also given to the pressures which have exerted a positive effect on nurse education.

3 GENDER ISSUES

3.1 The NHS reforms and the devaluation of nursing

Through the reforms of the NHS and the debates which preceded their identifiable start from the 1989 White Paper, and through the developments in nursing there are gender issues and differing perspectives to be seen. These are apparent in the priorities of the NHS and the reforms which concentrated on the relations needed to give greater emphasis to the needs of men in the NHS, that is the medical profession. The assumption being that the women would continue their usual role of silently supporting the men and by limited commentary on nursing in the reforms that nursing, midwifery and health visiting, would continue as usual (Davies C. 1995). Davies made a strongly critical assertion about the reforms in that 'The NHS leaders have resolutely refused to look at nursing.' and in her analysis saw this

as support for the commonly held view in feminist literature that women's work is largely invisible, being taken for-granted, and only noticed when it is absent (Davies C. 1995:166).

Similar views were offered by the Nursing Policy Studies Centre in a series of studies and papers which identified differing styles in the approach to the management culture between doctors and nurses. These were polarised between doctors being confident and challenging, with nurses being unconfident and deferential, with differences in power being evident and the 'handmaiden' image being perpetuated. The crucial analysis was that nurse education was weak and that nurse managers had received little support to develop their education and preparation for their role in managing a large workforce (Strong and Robinson 1990). It could be argued that the creation of the Nursing Policy Studies Centre, at the University of Warwick in 1985 was evidence of the need to provide a balance for nursing against the emphasis on medicine, however it had limited funding and only existed for four and half years; the demise was seen as a demonstration of the devaluation of nursing which had been the original focus of its academic purpose (Davies C. 1995). The research by Strong and Robinson showed nurses as 'unconfident' in their work roles and relationships with the medical profession. Health visitors by having their own caseload, not based on referral from general practitioners have been in a somewhat different role with the medical profession.

However, as workers within the NHS machinery, they have also been subject to similar managerial pressures as nursing colleagues.

In keeping with the reforms and the value for money culture there was an increasing emphasis on accounting for performance and achieving acceptable outcomes which could be identified and measured. The analysis by Davies C. (1995) offered a number of ways of looking at how the new managerial climate appeared to privilege men and to downgrade women. She identified a new trend in the use of overt gender terms, such as 'men in suits' and health service staffs describing the style of management as being aggressive and confrontational. When offered appropriate venues for discussion, women were questioning the 'macho' style of management and the need to put in long hours of work. Davies' interpretation was that there was little place in the new managerial model for factors such as commitment and altruism which bring nurses into nursing, nor room for the interdependence and vulnerability that are a feature of women's behaviour. This was linked with the centrality of caring in nursing, which now was hidden by the emphasis on rational decision making and the outcome measurement culture. Davies described the need to engage in 'unmasking' of values associated with masculinity which tend to denigrate issues such as dependency by feminising them. The issue of caring as a hidden aspect of health visiting became apparent through the data, and ways in which it could be made more overt are considered in chapter five.

In health visiting there were many managerial changes, with non-health visitors becoming line managers, who were charged with introducing more visible accounting and clarity about health visitors as resources. Although these managers were frequently women, they nevertheless appeared to take on the style of management described by Davies in the paragraph above, and became associated with pressure for outcome measures and compliance in reaching target numbers for childhood immunisations and health assessments . At the same time, they were instrumental in setting up continuing professional development opportunities to comply with the PREP requirements. They were also attentive to the changes which were being created for increased autonomy, for example through the possibility of health visitors and district nurses prescribing a limited formulary for their clients (Crown Report, DoH 1999b). Changes in the autonomy of nurses was seen from the ‘outside’ as a gender issue, but from the ‘inside’ was seen as part of clarification and application in practice of the educational changes resulting from a more academic preparation for the work (Rivett 1998).

3.3 Nursing seen as influenced by feminism

Medical commentary saw the education of nurses and the development of nursing autonomy negatively and as influenced by feminism. In particular this was seen in the approach to multi-disciplinary working, in the more scientific approach to nursing/health visiting known as the ‘nursing process’ and in the possibility of nurse

prescribing. One of the pressures for change in health visiting, as well as other community nursing services, was a review of the community nursing services, chaired by Julia Cumberlege (DHSS 1986). This recommended a much closer partnership with general practitioners, the identification of neighbourhood nursing boundaries, a common core educational experience, closer nursing management of practice nurses, greater community experience for all nurses and the introduction of nurse prescribing. The report was never put into operation although some aspects were fully developed during the next decade, for example the inclusion of practice nursing within the specialist community nursing programmes (UKCC 1997) and the formulary for nurse prescribing (Crown Report 1999b). However opposition to this report was noted in gendered terms in the following comment found within a comprehensive history of the NHS

The subliminal feminist agenda, appealing to nurses, was of nurse prescribing, nurses managing their own services and nurses negotiating with GPs as equals within primary care teams. (Rivett 1998:331).

The prospect of equality between nurses/health visitors and doctors is the subject of this disparaging remark; teamwork and multidisciplinary work as a feature of client care appear as subversive in this kind of comment. At the implementation of the nursing process there was much criticism in the medical press, as though nursing was contravening a code of practice and its place in society (Mitchell 1984; Tierney 1984). Health visiting appeared less implicated in this debate, it had already attained more distance from medicine, and had for many years operated a systematic

approach to client assessment. Comment about the need by nurses for support from medical practice in order to achieve its aims was made. The fact that there was a reduction in the alliance was seen as evidence of a 'feminist and political agenda' which resulted in nurses reducing 'their contact with the medical profession at a time when they would have benefited from a powerful professional ally in the fight to maintain standards and establishments' (Rivett 1998:346).

The necessity for these kinds of comment about gender issues in relation to nursing developments strongly suggest a truth within the writings of Davies C. (1995) of the NHS being a gendered organisation. However, there is also some truth that feminism, albeit not from a strong nursing voice, has contributed in many ways to the changes for women workers in education and health care (Pascall 1997). Project 2000 and the post-registration continuing professional developments have made a contribution by raising the educational status of a large female workforce. Therefore the analysis by Rivett does reflect the ideological changes that were part of women's personal and professional development during this period of time and the difficulty which the dominant ideology had in accepting these changes. The strength of the gendered view shown here is an indication of the prevailing view about women's needs and what areas of work might be considered legitimate and contribute to public visibility.

Conclusion

This chapter brings to a conclusion the background context to the study, which was set in a particularly challenging time for health visitors. All the participants were affected by the changes and pressures which have been documented here and in the previous chapter. The next chapter discusses the methodology for the research and shows the details of the health visitors who volunteered to participate in the research. Following that, chapters five, six and seven present an analysis of the views of the participants and show them concentrating on the less measurable aspects of health visiting, rather than the targets and more measurable dimensions which have, of necessity, been identified here.

CHAPTER FOUR

METHODOLOGY

Introduction

This chapter assumes qualitative methodology as a legitimate basis for research design. The arguments for and against the qualitative and quantitative paradigms will receive brief comment, instead there will be some debate about issues found within the qualitative paradigm. Further, there will be an argument to show that a new area of debate is between orthodoxy of research design and that which draws on principles but does not conform to an original named methodology. Insights drawn from research literature, educational and feminist qualitative research will be developed and applied to the methodology. Various types of qualitative research are discussed in order to place this work within a context that is applicable to exploring personal perceptions and epistemological issues for the health visitor. Links will be made back into the literature review to show how key concepts and questions were used in preparing a conceptual framework to guide the design. The data collection alternatives are explored briefly and discussion about the choice and managing rigour over a period of time is considered. Decisions about the sample size, participants, and access are discussed, and suitability of the data collection method confirmed. The final section in this chapter shows the analytical methods for organising and interpreting the data.

The key issues were the decision to use principles of qualitative design and to find ways of combating familiarity and personal assumptions when interviewing the health visitors and analysing the material. Managing the tools for interviews, providing check lists for myself and ensuring that participants had sufficient time to develop their ideas were all challenging. In addition developing an effective organisation and interpretation of the data brought a further set of issues in developing new knowledge and skills.

1 QUALITATIVE RESEARCH

1.1 Qualitative Research : debate with the quantitative approach

Philosophical debate about the nature of reality has generated much division between the scientific and naturalistic paradigms and at the same time has become involved in debate about methodology and methods. It is assumed that the reader of this research has some understanding of the relative strengths, weaknesses and purposes of the distinctive quantitative and qualitative methods of conducting research and its associated interpretation of data which reduces the need to rehearse some of the known debates. However it is also acknowledged that there will be those unfamiliar with these debates, including those who are charged with responsibility for ensuring that evidence-based practice is utilised where possible in

health care, social care or education and therefore a brief commentary on the current position will be made.

At the centre of the debate are questions and interpretations about the nature of knowledge, science and 'truth' which recur in ways that 'commit the [qualitative] researcher to a critique of the positivist project.... and qualitative research to... an ongoing critique of the politics and methods of positivism.' (Denzin and Lincoln 1998: 7, 8). This defensive position arises as a response to the ways in which the positivist tradition seeks to maintain a distinction between what is seen as hard science, based in disciplines such as physics and chemistry and the soft sciences of a more interpretative tradition such as sociology and education. This debate is seen as an illustration of political power about sources of knowledge and truth. In the NHS there has been a strong movement towards evidence-based practice in which research findings, especially quantitative research and randomised controlled trials are being seen as the way forward for medicine and nursing (Gray 1998; Walshe and Ham 1997; Godlee 1994; DoH 2000b). This also includes health visiting (Adams 2000; Cowley 1999).

A Systematic Review into the effectiveness of domiciliary visiting in health visiting showed little evidence of randomised controlled trials in the United Kingdom. There were some in North America from which some evidence of worth could be extrapolated (Elkan et al 2000b). However, in health visiting, as well as there being

pressure for evidence-based practice, there is also a recognition that measurement and randomised controlled trials may not be possible for all aspects of the work (Cowley 1995a; HVA 1995). Scientific knowledge is being required in order to justify human resource expenditure in all areas of work and there is a need to conform to expectations of research based practice in respect of clinical governance (D o H 1998a). Within the arguments that patients and clients should receive the best available care, there is an assumption, thus a political pressure, that quantitative evidence is the most desirable.

Recently, the Health Technology Assessment panel commissioned a review which would assist research commissioners and users ‘make appropriate purchasing and utilisation decisions’ in respect of qualitative research for the NHS (Murphy et al 1998). Their findings supported the value which qualitative data could give towards setting benchmark standards in respect of different aspects of patient care, using the rationale that the key focus of qualitative data is ‘the social world and the concepts and behaviours of people within it’ (Murphy et al 1998 : vii).

It is not the intention to argue for the qualitative position, but rather to assume its place within what is now an established tradition (Denzin and Lincoln 2000). Their generic definition for qualitative research covers a broad span of activity and concepts:-

Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretative, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to the self. At this level, qualitative research involves an interpretative, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them. (Denzin and Lincoln 2000:3)

This aptly sums up the way in which this research was designed, to consider the place of the researcher and to make sense of part of the world of health visiting. Within practice based employment, for example nursing, health visiting and education, there has been an increasing emphasis on qualitative research as a means of providing an analysis of processes and meanings within the work settings. The literature review showed this in a number of ways, including research into health visiting, emotional labour and nursing.

1.2 Qualitative research : debates within the paradigm

Current debate in qualitative research has moved to the variations within the paradigm and ways in which methodology should fit with the research questions. Flexibility and suitability of method can be contrasted with orthodoxy and rigidity of method. In respect of educational evaluation research, Patton has argued that researchers should consider

... methodological appropriateness rather than orthodoxy, methodological creativity rather than rigid adherence to a paradigm, and methodological flexibility rather than conformity to a narrow set of rules. (Patton 1990 : 295)

Not all researchers take the view that progress is made through flexibility in methodology. For example there was a plea for maintaining a clear identifiable methodological design and an express view by Jacob (1987:1) that educators in educational research should 'employ the totality of a tradition, not just generic assumptions or methods.'. One of the arguments expressed by Jacob, was that a confusion about methodology exists within the North American education literature as a result of employing the generic term of 'qualitative research' as an alternative to quantitative research, but without naming the variety of approaches available within the qualitative or naturalistic paradigm. This is also a view promulgated within some North American nursing research literature, where there is a plea for orthodoxy and concern that 'qualitative methods are suffering from a lack of protocols and are becoming increasingly unstructured' (Morse 1991). However other North American nurse researchers have defined qualitative research as an unstructured approach, although recognising that there are particular research designs within this overarching context (Polit and Hungler 1999), indicating that there are conflicting views through both nursing and educational research about the degree of structure and orthodoxy required.

A British critique of the paper by Jacob (Atkinson et al 1988), drew attention to arguments being focused on boundaries and science within the qualitative paradigm as well as between the two key paradigms of quantitative and qualitative research.

Throughout the twentieth century there have been developments in qualitative research in many fields of study including education, sociology, nursing as well as others, so much so that there is a history which recognises that qualitative research is now a 'field of inquiry in its own right' (Denzin and Lincoln 1998 : 2). Questions are now being raised about mutual understandings of research design and traditions since it is clear that there are differences which can make comparison difficult. Atkinson et al (1988) provide a slightly different analysis of origins and philosophies compared to Jacob and reveal some inconsistencies when applying their interpretation of traditional methodologies. Their key terminology included recognition of 'approaches' but their preference was for the terminology 'types of research rather than distinct traditions' because of the difficulties in practice of making clear separations across the traditions (1988:235). They also identified the omissions of feminist and neo-marxist research in Jacob's analysis. In a more recent article the term 'perspective' is used as the overarching dimension which is then informed by the research design (Punch 2000). This kind of debate demonstrates the problem with terminology and interpretation for the researcher new to the qualitative field. In this thesis I have used the terminology of 'the approach' to define the qualitative feminist research which was undertaken.

The complexity is heightened by the way there appear to be different historical outlooks operating simultaneously in the present, described by Denzin and Lincoln (2000) as the seven historical moments, which also produce different

epistemological outlooks moving across the seven moments. These historical moments are given in time spans, but their interpretative point for this argument is that as well as being derived in a particular chronological sequence they are *all* being utilised in the current era and with some overlaps. Thus, 1900-1950 traditional; 1950-1970 the modernist or golden age; 1970-1986 blurred genres; 1986-1990 the crisis of representation; 1990-1995 the post-modern, a period of experimental and new ethnographies; 1995-2000 postexperimental enquiry; and the future which is now 2000 - ongoing, is concerned with moral discourse, with the development of sacred textualities, a much more global and community orientation (2000:3).

Significant texts have appeared which are derivative and draw on a number of original sources to produce an application for the researcher of the late 1990s. For example a general understanding of qualitative analysis which sets out principles of design and analysis without upholding one type or tradition (Miles and Huberman 1994). In education the texts by Patton (1990 : 292, 293) explicitly state there is now better understanding and balance in the debate about the relative strengths and weaknesses of the quantitative - qualitative methodologies, which allows support for 'methodological eclecticism and increased methodological tolerance'. Holland and Blair (1995) are editors of a text with an agenda of addressing the debate within feminist methodology and epistemology and which shows methodological variation over time and in current practice. Also in the medical field of primary care,

considerable work has been developed which is clearly ‘second generation’ work, is built into an appropriate methodology, acknowledging original roots, but moving forward into a more eclectic position for data collection and analysis (Crabtree and Miller 1999).

1.3 Qualitative research and feminist research methodology

Within the naturalistic paradigm and in traditional feminist research a number of tools appear common, such as the in-depth interview and observation, and this study does not make an exception to this practice. Nevertheless it contributes to the debate about terminology and data collection by affirming some definitions and linking these to the historical and current discussion about methods and methodology. From an historical point of view, Herbert Blumer (1978) notes that

Methods are mere instruments designed to identify and analyse the obdurate character of the empirical world, and as such their value exists only in their suitability in enabling this task to be done. (1978 : 32)

The terms ‘methods’ and ‘methodology’ have regularly been confused but the definition by Blumer clearly identifies methods as tools. This understanding is confirmed in more recent writings when clarification from the feminist view point was produced by Harding (1987), in which ‘methods’ are identified as particular procedures used during research. It would be appropriate to consider tools and methods as neutral and available to all paradigms. In practice, that which lends itself

to numerical analysis is used as a tool for quantitative research and that which provides textual material is used for qualitative work. Of themselves a tool or procedure should be used according to suitability for the task.

Methodology then has to mean something else, and is not to be confused with method; Harding defines methodology as the broad principles about the conduct of research and how theory is applied, and suggests there might be an underlying feminist approach to research which could be traced and used to produce a set of guiding principles for researchers wishing to use a feminist paradigm. It seems logical to suggest with Jayaratne and Stewart (1995) that there may be a feminist methodology of principles and characteristics.

It is not surprising to find that feminist research has been part of the historical development of qualitative research, placed in the seven moments within the modernist or golden age and the blurred genres (Denzin and Lincoln, 2000). In keeping with the arguments in this chapter, the view presented here is that it is a methodology which has its roots in the 'alternative' naturalistic paradigm with a strong emphasis on participant involvement and equality between researcher and researched. Feminist research had its roots in the early period of feminism when there was considerable focus on women's subjectivity. However feminist research has now expanded to embrace all kinds of research, including experimental work,

with debates and differences which extend across managing voices in the text and how to utilise research for policy (Olesen 2000). A link between the variation and complexity of research design with the 'second phase' of the women's movement was made by Olesen, who continues to see feminist research as a dynamic process. Although it is possible to make some mapping of research styles with differing feminist perspectives, it is more helpful to see the variation in methodology as part of the dynamic nature of research.

Within the British nursing research debate there have been differing views about what constitutes feminist research. This appears to replicate the debates about following clearly defined research types or moving towards methodological tolerance as described in the previous section (Patton 1990). In an article, illustrated with a research study in a gynaecology setting, described by Webb as being within the context of medical hegemony, she asserted the need for clarity and change.

Feminist research, then, changes the nature of the relationship between researcher and researched by making women's experiences visible and it does this through the medium of consciousness, asserting that in research as in all social life the personal is the political. (Webb 1984 :251)

Webb (1984) proposed her view about feminist research in terms of purpose, consciousness raising and the political aspects, thus placing herself within a feminist standpoint position and second wave feminism; perhaps very necessary, given the

hegemonic stance revealed through the process in her study of meeting the requirements of the Research Ethics Committee and of access to the women patients. The check list approach to feminist research would include the following features:-

- the principal investigator is a woman
- the purpose is to study women and the focus of the research is women's experiences
- the research must have the potential to help the subjects as well as the researcher
- it is characterised by interaction between researcher and subject
- non-hierarchical relations and expression of feelings and concern for values (one or all may be incorporated)
- the word feminist or feminism is used in the report
- non sexist language is used
- bibliography includes feminist literature

(adapted from Duffy 1985)

By contrast, some nurse researchers proposed working from a set of essentials which would show 'what it is to view the world through a feminist lens' rather than work to a rigid framework (Siebold et al 1994:395) and a different way in which to investigate nursing (Sigsworth 1995; Webb 1993). Examples from health visiting of engaging in this debate are very rare apart from the study on domestic violence which utilised a feminist analysis (Peckover 1998). Guiding principles in midwifery feminist research are suggested as:-

- that women's experiences are the major object of the investigation
- that the researcher attempts to see the world from the point of view of the woman
- that the researcher is active in trying to improve the lot of women.

(Draper 1997:599)

The more rigid model for feminist research creates difficulty for researchers who through a reflexive process become aware of a changed position as their research and reading progresses. For myself in the earlier stages of the research, I saw feminism and feminist research as an ideology which I had not understood nor was willing to endorse. From an academic perspective I had become aware of the difficulty that this area of study might pose in the academic world, mirroring many of the findings discussed in the case study by Coate (1999). Also, as a health visitor I had little exposure to feminist writings, as noted above, there were some scholarly debates about feminism and research in nursing, but little in health visiting. Gradually there became a realisation, as with Finch (1984) that through the research a commitment to feminism was being developed, that a 'personal transformation' of outlook was developing (Bartky 1990:11) and new ways of looking at health visiting and the relationship between health visitor and client could be seen. There was a deeper realisation of the focus of the study being the fact that health visitors as women were also mothers, sisters, daughters, aunts, partners, and that the empirical work needed to show the 'whole person' doing the job not only the 'professional woman'. A further working hypothesis became :-

'that health visitor education ignores the personal contribution made by individuals in favour of the professional, objective stance'

2 DESIGN ISSUES

2.1 Dealing with familiarity and the role of the researcher

The development of a feminist methodology came through an early decision in the research design to apply a gender lens as a means of dealing with familiarity. From my background as a lecturer in health visiting there was the recognition that it might be difficult to stand back and develop an understanding that was not filtered through my own perception of health visiting. These debates about the advantages and disadvantages of conducting research with knowledge of the participant's areas of work was explored. The debates ranged through the positive ability that personal knowledge had in creating rapport, and of being supported in gaining access, to the negative aspect of not being aware of nuances and important distinctions that are different from the researcher (Loftland & Loftland 1984; Burgess 1984).

However it is also axiomatic that one would expect a practitioner to conduct research into their own professional field as with any academic discipline. In reading research conducted by health visitor researchers it appears a 'taken-for-granted' assumption that their work is with health visitors without discussion of familiarity (Robinson 1987; Cowley 1991; Kendall 1991). Other significant health visitor researchers may not have addressed this because of being a different nationality and with a different prior public health or community education, that is Canadian, (Chalmers 1990) and Spanish, (De la Cuesta 1992).

Reading in the area of familiarity gave ideas for managing the potential problem and a method of assisting greater awareness and revealing assumptions, was seen to be the application of a lens that would provide a different perspective. In particular Delamont (1992) was persuasive in suggesting the gender lens as highly appropriate when working with familiar settings; particularly her comment about the paucity of gender as an organising principle in the sociology of education. She also questioned the lack of gender comment in a number of school ethnography's, particularly when comparing British work with that undertaken in North America. After I became more deeply aware that very little comment had ever been made on the fact that health visitors, mainly women, were visiting mainly women, I returned to her observation on the fact that it was odd that in highly relevant instances there was no appropriate mention of gender issues. I concluded that this must be noteworthy and of relevance to the history and conduct of health visiting, even though at the time I had little knowledge about how to utilise a gender lens.

At the time, the term 'lens' appeared as an acceptable orientation, more neutral than an ideological stance and permitted a way of having a main theoretical focus plus subsidiary orientations rather than taking an ideological stance (Patton 1990). This position provided the basis for identifying the key concepts and variables to be explored and located the stance for analysis. Patton argued that the extent to which a lens and a full orientation operated was a matter of degree and interpretation.

This suited my view at the time, as it gave a way forward that did not immediately say to colleagues that this was feminist research. With hindsight, I would have preferred a clearer view that this was the undertaking, as it would have provided a basis for more defined essentials of feminist research being employed and would have given a clearer position to the participants.

Another strand within the literature on qualitative approaches discussed the role of the researcher as a greater or lesser part of the empirical process. It seemed a fundamental part of the process that I would question what effect my assumptions and background would bring to the research, and how this might affect data collection and analysis. This, together with the views about familiarity, confirmed for me, that I needed to address and confront my own position within the research. The reflexive approach to research design has been evident throughout the work, revealing insights commensurate with the views expressed by Jayaratne and Stewart (1995) that the majority of women researchers have been prepared through traditional quantitative ways and that this may result in reluctance to embrace other perspectives. Although not reluctant to embrace other perspectives, it was an ongoing process of learning to be aware of nuance and accommodate a different paradigm.

... and despite any interest in alternative procedures, it is far more likely that they [women researchers] will carry out their research largely using traditional methods and methodologies. (Jayaratne and Stewart 1995: 225)

This rather sweeping statement is difficult to verify, and turns upon the definitions of traditional and alternative as signalled earlier in the chapter. As noted earlier, the intention is to assume in this thesis that qualitative work is now a tradition, especially within nursing, health visiting and education, and that the argument for its veracity and contribution to knowledge is to be made within its paradigm perspective and not by contrast with quantitative work.

2.2 Conceptual framework and research design

An ongoing theme underpinning the research has been the lack of transparency and the invisible nature in some of the processes of health visiting. Initially the focus explored the external view of an undervalued professional group, set in the context of a changing National Health Service and a changing educational emphasis being guided by national agendas for initial and continuing education in nursing. Gradually the focus of the empirical investigation moved to individual perceptions by health visitors of themselves and their work as a way of increasing knowledge about the process of health visiting and the interplay with interpersonal issues as seen through a gender lens of women's voices. From this the working hypotheses and conceptual framework became more focused towards researching health visitors own perceptions about practice and education. The aim was to uncover and make more transparent the work which is essential but assumed within interactions between the health visitor and her female client. This also appeared to have a

relationship with life long learning within the personal and professional development arena (Jarvis 1992).

The conceptual framework picked up these issues and followed a sequence from Miles and Huberman (1994), which is that the conceptual framework feeds into and is fed from the research questions, both of which feed into the sampling plan. At the data collection phase there is a loop back to the conceptual framework, and at the interim analysis stage there are loops back again to the conceptual framework and also to the sampling plan and research questions. This is not meant to undermine the rigour of planned design but allows for one of the crucial advantages of qualitative research which is that a responsiveness to the data can occur in a dynamic and incremental fashion. For example in this research, deepening the feminist orientation by increasing focus on appropriate concepts through all phases of the research and for example the concepts of personal and professional experience as resources. This iterative process has allowed for different phases of development, and for reconsideration of issues as field work and reflexivity raised questions that were not, or could not, have been foreseen at the initial stage of the research. This is in keeping with the assertion that 'Conceptual frameworks are simply the current version of the researcher's map of the territory being investigated' (Miles and Huberman 1994:20).

From educational evaluation work there was precedence for linking the personal and professional, for example Patton reporting on a study, titled 'Wilderness Experiences and Group Processes', discussed findings that the personal-professional distinction was arbitrary, and that for participants there was a major theme of '...reducing the personal-professional schism, the desirability of living an integrated life and being an integrated self.' (Patton 1990:454). The realisation, that personal/professional was a legitimate focus in educational research, resulted in a re-visit of the conceptual framework and a clearer structure for the data collection in this central phase of the work. There was movement from exploring how the health visitor as a female professional engaged in her job, through to exploring how a woman drew on her own resources of life and professional experience to do the job. The depth and frequency of using the self as a resource was seen as a contribution to the debate about the process versus product or outcome aspect of health visiting. This in turn would raise issues about initial education for the work. The intention of inviting personal and professional views about health visiting was expected to provide a source of information about the continuing educational needs for the job and to develop the concept of experience within the work.

This preparation fulfilled criteria in respect of feminist research by a design which explored women's perceptions and by having outcomes which could influence women as workers and women as clients. The preparation for the design methods also contributed to confidence that gender issues were an acceptable area of study.

The finding of educational research in the personal/professional arena was helpful and showed a way of bringing these aspects together.

3 DEVELOPING THE METHOD

3.1 Developing the interview schedule

It was clear from early in the research design that individual and group interviews would be needed to explore health visitors' views of their work, and developing the method included practical skills for managing the tape recorder and transcripts as well as the interview schedule itself. Interviews were seen as the most appropriate, giving the opportunity to explore the views of health visitors through conversation (Burgess, 1984; Patton 1990), also to fulfil the task suggested by Blumer (1978:40) of using a tool which allowed the researcher to discover aspects 'beneath those known to his informants'. Other tools such as observation were therefore not developed.

The management of the interview schedule was subject to an iterative process of evaluation following the early interviews and moved from a topics list to a more structured sequence. The pilot interview instrument was prepared as a guide and followed the ethnographic approach of providing issues and topics for a reflexive style of interview, and as a semi-structured instrument it allowed comparable data

to be covered across participants (Lofland and Lofland 1984; Hammersley and Atkinson 1995; Bogden and Biklen 1992). The limitation of the 'key topics schedule' was seen in the difficulty of applying consistency across participants, and also in keeping track that the main issues had been covered during the interview. Full sentences were constructed for questions and an order decided upon which was not dissimilar to the first schedule, but the content was expanded to include issues which had been seen as important by the exploratory group and the pilot study participants. For example, the impact of changes in their own family life, particularly having children, was said to have changed perceptions held by clients about the health visitor. This comment was offered spontaneously and strongly in two sequential interviews, conducted in very different geographical areas and different parts of the country. Another development was to ask specifically about being a woman health visitor as a more direct method of obtaining data about differences in health visiting by men and women, rather than the general prompt of differences that might occur between by them.

The individual interview schedule became structured into four sections, reflecting much more closely the conceptual framework and the inter-relationships which were being explored. The four sections were identified as work context, own family context, women and application, and knowledge and skills; this further refinement was the result of working with the data and the need for an organising mechanism during the interviews. The interview schedule can be seen in Appendix One. The

four headings also provided a structure for the participants and provided ways in which to introduce topics and move interviews forward. The interview schedule for the second group interview was prepared in a similar way, but only three sections were used :- practice and work with women, personal and family life, and knowledge and skills. This reduction was seen as a way to focus quickly on key issues to accommodate a fairly tight timescale required by the group. The group interview also gave an opportunity to try a number of slightly different questions, designed to extend the issues being explored; it can be seen in Appendix Two.

Further reading about questioning and seeing a deeper view of the possible range and kind of question prompted inclusion of particular dimensions within the questions as a way of enriching the data, see Figure 1. These dimensions were put within a time matrix of past, present and future and each question was checked for being open ended, neutral, singular and clear (Patton 1990). An evaluation was conducted on the pilot interviews using a matrix constructed from the above points. This proved a useful way of planning and preparing for the range of questions and topics and gave a comprehensive overview to cover dimensions which might have otherwise been overlooked.

Figure 1 : Matrix to relate type of information with a time frame (adapted from Patton 1990)

Type of information	Question number	Past experience	Present experience	Future anticipation
behaviour/ experience				
opinion / value				
feeling				
knowledge				
sensory				
demographic/ background				

3.2 Purpose of interviewing

It was a personal revelation to find the view expressed by Blumer (1978) that the purpose of interviewing was to go below the surface of that known to the participants, and to be constantly open to looking at the area of study in different ways. Blumer discussed the need, in exploratory research, for the researcher to be alert for the need to test and revise their own images, beliefs and conceptions about the work.

Part of such testing and revision will come from direct observation and from what informants tell him, but *since his task extends to probing into areas beneath those known to his informants*, he should cultivate assiduously a readiness to view his area of study in new ways.

Blumer (1978:40, my italics)

Before finding this significant comment my emphasis had been on the need to understand and report upon the identified perspective of the participants. However, I now had a reference point to direct me into what I anticipated as questions and responses which would go *beyond* that normally discussed and consciously known by health visitors. Going beyond what was usually discussed was also the role of the gender lens and feminist concepts and theory within the conceptual framework and design.

At this point I confirmed the focus as health visitors and that the study would not include clients. There has been criticism of research focusing on health visitors without including clients because it may give an unreal or partial description of interaction which could not be verified. Different perceptions of topic and value had been the experience of Kendall (1991) in her doctoral research with both health visitors and clients. However it is contended that this research is about health visitors own perceptions of their work, without ascribing a value, whether negative or positive, by the clients. It is also partially about self awareness and an ability by a health visitor to relate personal life events to client situations in a natural and woman-to-woman way. Although individuals may behave differently in other settings to that which they have described in an interview, the veracity of the information given by people in self report, can nevertheless be considered as *real* information about attitudes, feelings and behaviour. Self report should not be down-played in value (Hammersley and Atkinson 1995). Value in self report has

underpinned the empirical part of the study, so that although no clients confirm the perceptions of what health visitors describe as taking place, nevertheless it has a truthfulness of its own, and should be counted as reliable data.

A group interview had been conducted early in the research process to check the relevance and interest of health visitors in the kinds of topics being considered. Another group interview was planned during the main study to give opportunity for identifying concepts or hearing ideas which might emerge through the interaction, which could then be explored through the remaining individual interviews. Group interviews have a long history, Blumer (1978) valued them highly as a means of achieving a discussion and disagreements which could 'lift veils'. They are a means of generating data and insights from group interaction (Crabtree and Miller 1999). In the event, no veils were lifted, but the second group interview did serve to confirm that the topics were of interest and credible as issues in health visiting.

4 SAMPLE DESIGN

4.1 Identifying the sample

After searching for guidelines from the literature a figure of twenty individual in-depth interviews was proposed after conducting the exploratory interviews. Patton (1990) emphasised that in qualitative inquiry there could not be any set rules for the

sample size, but rather there needed to be a close link maintained with research purposes and outcomes. Other writers suggest fifteen to twenty participants will usually yield sufficient data to provide a basis for analysis, beyond which repetition and redundancy of information may start occurring. The numbers required are a matter of researcher judgement and the advantages and disadvantages for more or fewer are shown in Figure 2, the key issues were drawn from a variety of sources.

Figure 2 : Attributes of sample size

In -depth information	Less depth achieved
Small number of people	More people
Information rich	Documenting diversity

This accords with Lincoln and Guba (1985:202) who stated that

The validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information - richness of the cases selected and the observational/analytical capabilities of the researcher than with the sample size.

This is supported by Hammersley and Atkinson (1995) who express similar views with respect to not having a fixed number or type of respondent. Their view is that in the choice of informants, there is not a right or wrong decision, but only ‘better and worse ones’, and the effect of these decisions may not be apparent until later in the research. They also considered the issue that criteria for choice of interviewee may change over the course of the research. In this study a decision was made

during the interviewing phase to include two participants who had been practising health visiting for approximately one year. The inclusion criteria was that the participants should be experienced health visitors, suggested as two years by Clarke (1985) and five years by Benner (1984); the latter number of five years was seen as the most appropriate for the range of topics and their application to the work which was being explored. However, the inclusion of the two less experienced health visitors, was partly to test out the ability to draw on life and professional experience occurring before working as a health visitor, and also to compare other views from an early rather than a later perspective.

People with the appropriate knowledge, who are keen to divulge their knowledge, are suggested as the ones to target in a strategic selection. The caution in selecting strategic volunteers is the person who for one reason or another is frustrated, needy or in other ways may not give appropriate information to the researcher; but selection is based upon the best judgement at the time (Hammersley and Atkinson 1995). Health visiting is a relatively homogenous group, with a similarity of understanding but in order to ensure a wide range of views it was decided that the health visitors recruited to the study would come from a variety of sources.

In his recommendations for building a participant pool, Siedman (1991) argued that the most important criterion for selection is that the participants experience and the focus of the study are compatible. This he considered to be purposeful sampling,

with a recommendation of maximum variation as an effective sampling strategy; this became the strategy adopted in the study as questions about the comprehensive nature of experience and practice became obvious through the period of data collection. Siedman also argued that there is always an element of self-selection in an interview study and that it is not compatible with the concept of randomness. His view is that the researcher reveals to the reader the kind of detail and depth which resonates with the reader's own experience and that the reader also develops more comprehension about the experience being presented through the analysis of the qualitative work. This is one of the ways in which validity of findings are confirmed, for example 'consensual validation and judgement' (Patton1990:184). It also contributes to the concept of generalisability of findings, which in qualitative work is not possible in a statistical sense, but is available through resonance in the reader, of the findings (Morse 1991).

4.2 Purposeful representative sampling

A subtle change in terminology became apparent through the research period, in which 'subjects' became 'participants' as a deeper understanding of qualitative and feminist research was developed; other terminology noted was 'informant', 'interviewee' and 'recruit'. This supports the view of Jayaratne and Stewart (1995)

discussed earlier, in which vestiges of a quantitative heritage may be difficult to remove. For me, this was exhibited in terminology, but also shows that going beyond my primary education in quantitative work did take place.

A number of practising health visitors were enrolled on an evening diploma course and were contacted through the course tutor asking for volunteers to take part in a discussion about health visiting as part of my research. A letter of explanation was provided, and attendance at the session was taken to be the informed consent. Six health visitors participated in a lively discussion during December 1995. Gender issues and men in health visiting were identified as areas of considerable interest, and from the notes and transcript it was possible to link the discussion points with concepts from the literature as worth further exploration.

During 1995, I attended a conference on Reflective Practice, at which there were presentations by health visitors on the outcomes from attending a module on reflective practice during a post basic diploma course. As the research focus being developed included health visitors own perceptions on practice, I was very keen to interview some members of that module. Subsequently, I wrote letters of introduction which were forwarded through the University Department, with an arrangement which maintained the privacy of the module members. Two health visitors from different health authorities contacted me, whom I interviewed separately in the summer of 1996. At that time, I also discussed my research proposal with a community manager who then asked staff for a volunteer, so that I

also interviewed one other health visitor at this time. These served as early pilot interviews, enabled my development in managing unstructured interviews based upon topics, and continued to confirm the direction of the research as the process of work with the woman in a variety of ways.

Two of these early interviews revealed a strong view that personal experience influenced health visiting-client perceptions of the authenticity of the health visitor, principally in the matter of having their own children. All three interviews upheld reflective practice and continuing education as relevant to current practice. By the end of 1996, the direction of the research was clear in its focus on the perceptions of health visitors and in particular their work as women with women. Further refinement was undertaken on the interview schedule, and two more pilot interviews conducted in June 1997 with health visitors who had been part of the December 1995 group interview. This was helpful in giving some continuity of contact and assisted in promoting a relaxed approach to the interview and piloting what were to be the final key topics for the empirical research .

Throughout the period of exploratory interviews further reading in methodology continued and the transition to a more equal relationship between researcher and researched was taking place. However, with hindsight this did not reach a fully developed model of equal participation, because I did not set up an opportunity for participants to read and comment upon the transcripts. This was for two reasons,

initially my lack of appreciation that this was an option, and perhaps fulfils Jayaratne and Stewart's (1995) rather negative expectation of those who move from quantitative research to qualitative research modes. Secondly, I was influenced by the view that ethically, having set up a relationship which was stated as finished at the end of the interview, I should stay within this agreement. This fulfils the recognition that the researcher can be seen as the more powerful in the relationship, and that making further contact when it was not expected would be an infringement on the participant. Towards the end of the interviewing period, I had introduced the possibility of further contact if there were issues on the recorded interview that were not clear or were ambiguous.

4.3 Ethical issues, access and the sample

As a means of developing a participant pool access was given for two presentations to different groups, both of whom were made up of experienced health visitors who would fit the criteria for experience. Siedman (1991) recommended access through peers, or through a group, to gather a list of volunteers and then to set up a preliminary contact visit following a telephone call to ascertain level of interest and to initiate the process of informed consent. The primary concern at the access meetings was to provide sufficient information about the planned areas of the research so that the health visitors who were prepared to talk freely about their experiences would know what to expect. There was no attempt to seek

representativeness for particular perspectives, the only exception to this was at a point when there were sufficient volunteers to enable some stratification by the time span since qualification.

The access meetings for the planned individual and group interviews were through a local health visitor professional organisation, and the other through a meeting of community practice teachers being held outside of my own base area. I acknowledged my background as a health visiting lecturer and was known personally or by repute to some in both groups. Later, I was surprised by the extent of the trawl for volunteers, receiving telephone contacts or return slips from distances of up to forty miles and from some who had been encouraged to participate by their managers, as long as it was 'in their own time'. I had not accessed volunteers through the managerial system, having specifically wanted recruits who would be able to speak individually and not through an 'employee' framework. However in the interviews and analysis the employment constraints are quite clear from whatever source the participants were recruited, including the early exploratory interviews conducted through the reflective module at distances of seventy miles from my base.

A participant interview form to collect minimum personal data and contact details was prepared and distributed. Those which were returned were followed up by negotiation with respect to interview dates, time and place, with the guiding

principle being equity between the researcher and participant. The participant was given the opportunity to take the lead in the management of time and place. Letters of invitation can be seen in Appendix Three.

This research study required a number of health visitors to discuss their perceptions of changes in health visiting and the initial plan sought a pool of experienced practitioners who would therefore have a developed view of their work, have a variety of life and professional experience, and some views of appropriate continuing education needs. The in-depth information arising from this sample was expected to meet the purpose of the inquiry and have credibility with other health visitors as to the suitability of the participants.

A total of thirty five health visitors participated in the research. The two group interviews held six and four health visitors, respectively, and there were twenty five individual interviews. Demographic details showed a range of professional and personal information. The time since first qualification spanned twenty seven years, but the one who had been qualified the longest was one of those who had fairly recently achieved a relevant undergraduate degree. A total of twelve had degrees or were enrolled on a degree programme, one had a master's degree and one was enrolled on a Master's degree. Just over a third had undertaken a community practitioner teacher course, and all except six participants had participated in a formal certificated educational or professional course. The participants were

employed in one of eight health authorities and eight were also working within General Practitioner Fundholding Practices; the others worked in close ‘attachment’ arrangements with general practitioners. The personal data showed that the majority were in the category of married or with a partner, and of those twenty eight had children. Thus some were married and did not have children, some were now without partners and four considered themselves as single and also were without children. Two sets of demographic data are of particular relevance to the study and are recorded below in Tables 1 and 2.

Table 1 : Health visitor practice experience

Length of health visiting experience	Number	%
1 year	2	8%
2 - 6 years	4	16%
7 - 11 years	8	32%
more than 11 years	11	44%
Total	25	100%

This data is for all the individual interview participants, it was not obtained for the participants in the group interviews.

Table 2 : Educational background in addition to health visitor qualification

Educational courses	Number	%
Diploma	6	17.1%
Enrolled on diploma	6	17.1%
Degree	9	25.7%
Enrolled on degree	2	5.7%
Master's degree	1	2.85%
Enrolled on master's	1	2.85%
No additional	10	28.5%
Total	35	100 % (99.8%)
Community Practice Teacher	12 (included 4 from the 'no additional' category)	

The tables show a wide range of practice experience and also a workforce who have engaged with lifelong learning to enhance their qualifications, to keep pace with changes in the educational level of registered nurses at diploma level, and also the new level of bachelor degree for health visiting. As a group they meet the criteria for a purposeful sample in respect of the planned research. In fulfilment of confidentiality name changes have been made to all participants and a reduction in precise information about personal circumstances and location of work have been made to reduce the possibility of identification.

5 DATA COLLECTION

5.1 The interviews

The equipment for the interviews was kept in one place, with a check list for preparation before setting out for an interview. This comprised the paper work of interview schedule of questions, set of information about the expectations and process of the research, informed consent forms (Appendix Four) and writing paper; also the tape recorder, batteries and tapes. A battery operated tape recorder gave a better sound production than mains connected, and fresh batteries were used for every interview. A one hour interview was planned on each occasion, and in practice ranged from fifty five minutes to one hour and fifteen minutes. All interviews were fully transcribed, apart from the first group which was partially transcribed because recording difficulties inhibited a full account.

It was considered appropriate to permit a flexible order for questions, and therefore could be responsive to the interviewee, with varieties of questioning according to the function of the question. The conversational style of interviewing may appear to relinquish control and be led by the interviewee, but for effectiveness there must still be control and recognition that a research agenda is being fulfilled with rigour and consistency to aid validity for the research. This process is given the term 'active listening' by Hammersley and Atkinson (1995). Although they don't make links to other work on this point, it is a term familiar in counselling skills work, whereby

attention is given to a number of different responses, both at a verbal and non-verbal feeling level.

The conversational style, in keeping with the principles of ethnographic interviewing and feminist principles of equality between researcher and researched brought some difficulties which were apparent in the early interviews. A reflexive conversational style was used to pick up the direction of the participant, but resulted in me talking too much. This was assessed by a simple count of the number of dialogue lines in the transcript for myself and the participant which I made into a table for my own information. One early transcript showed a high proportion of me talking, for 47% of the time - almost half of the interview time. I am not aware of an ideal proportion but set a personal goal of a 30% : 70% balance, and became more aware of monitoring myself during the interviews. Tables 3 and 4 show the proportion of the dialogue and the personal change achieved to reduce my level of input.

Table 3 : Proportion of dialogue in the early interviews

	Interviewer (myself)	Participants
Exploratory& pilot study interviews	30% - 47%	70% - 53%

Table 4 : Proportion of dialogue in the main study

Main Study	Interviewer (myself)	Participants
20 Interviews and 1 group interview	18% - 49%	51% - 82%
14 Interviews		> 70%
4 Interviews		54 - 69%
3 Interviews		51 - 53%

These line counts are an approximation of the proportions and shows considerable participant data available for the analysis. Overall the total words from these transcripts were around 200,000, with a mean of 9250 words; the range was 7180 - 11,197 words in each transcript.

Further reading into the conduct of interviews showed how introductory statements and announcements about the progression of the interview could add a conversational dimension, interest and apparent interaction, without slipping into an inappropriate dialogue. This somewhat reduced the reflexive aspect of the interviews, but has resulted in more consistency across the participants and more time for participants views. The goal of consistency appears essential when the

sample size is modest in relation to the number of questions to cover in one hour. However, the use of illustrations by me to amplify a question were spontaneous and specific to the participant, and individual summarising statements were used to clarify views and to move the interview to the next phase, thus adding a conversational dimension.

A model was utilised in which I attempted to maintain what was described as ‘empathic neutrality’ (Patton 1990:56). This is displaying interest, encouragement and caring qualities to the participant and at the same time maintaining neutrality towards the findings by not commenting upon the answers and contributions. This is seen by Patton as a self discipline and a way of maintaining a non judgmental and open approach, and is used in conjunction with reflection and other means such as insight about potential for bias, selective perception and personal theoretical dispositions. The participants did seek reassurance that their contribution was appropriate, and were often self-deprecating and needed valuing during the interview process. I found this an interesting parallel with the purpose of the research, which had incorporated the reported sense of a lack of personal value in health visiting.

The role of the researcher as an instrument was acknowledged, and could be seen both in the interactional aspect and in personal reflection and also in changes towards the interview questions. The influence of the researcher on the interviewee

and how the interviewer changes through the process are discussed in the research literature. There appears to be some dilemma in applying consistency while at the same time developing increasing skills at maintaining a dialogue and refining thinking as the work progresses. This has functioned as an iterative process which I considered to be within the criteria for the conceptual framework I had used (Miles and Huberman, 1994).

6 ANALYSIS

6.1 Data organisation and data reduction

The principles underpinning data analysis are taken to be the same, whether for numerical or textual analysis, and these are noted as data organisation, data reduction, data description, data interpretation, and dissemination (Polit and Hungler 1999). These principles provided a framework for the analytic process for the study. Analysis is viewed by Patton (1990) as a phase of fieldwork, with its own requirements for monitoring and reporting upon procedures and processes adopted and the decisions made during the analysis. The analytical rigour should therefore be displayed through the account and the discipline in applying a systematic approach to the process should be evident.

The immediate need for data organisation and reduction was developed through the conceptual framework, using original questions and insights developed for the

interview schedule and during data collection. Significant patterns were identified and a framework was established to identify whether or not all transcripts contributed to each category of findings. The goal was to 'produce clear, verifiable, credible meanings from a set of qualitative data', which Miles and Huberman (1994:3) believe is possible by 'any method that works'. By that they mean that there are different ways of approaching qualitative analysis, which can be 'simple, practical and effective' using guidelines and procedures rather than strict rules. This does not over-ride the need for a systematic approach and rigour. The analytical design followed the principle of steps which became progressively abstract and interpretative (Crabtree and Miller 1992; Miles and Huberman 1994).

A thorough set of procedures was put in place in order to ensure completeness of all materials as part of the data organisation. All interviews had been tape recorded and following the interviews the tapes were played to ensure that recording was complete and audible, cassettes were checked for labels and date, and a back up copy made. One early tape had become tangled towards the end of transcribing which had served to make back up a regular feature. Rules of confidentiality and security were maintained by keeping the two sets of tapes in different places. The tapes were played and notes made from the first play back and kept with the field notes to provide a background and context for the analysis. One of the pilot interview tapes was blank and served as a reminder to double check at the start of the interview. An attempt was made to personally transcribe tapes with an audio-

tape transcriber since some authors had recommended this as a method of becoming deeply aware of the data. However it was extremely labour intensive and an experienced transcriber was engaged to undertake the majority of the transcribing; issues of confidentiality were discussed in order to protect the participants. Verbatim accounts were prepared, using Word 7, and checked against the tapes for completeness before obtaining three copies for data analysis.

These activities were mechanisms to promote quality control and included such checks as field notes, gaps in the expected data, interview transcripts and general overview (Marshall and Rossman 1995). Proportion of dialogue times were noted from the transcripts and review of the questions and issues were considered after the interviews. Keeping a track of progress with the production of the transcripts and the data and ensuring its accessibility for the next stages of data reduction and interpretation required vigilance and a systematic approach to sequencing and storage.

6.2 Data description and data interpretation

Initially each transcript was read and noteworthy phrases and utterances were highlighted and interpretative observations were made in the margins. The observations were reviewed and expanded and separated from the transcript with the relevant data in order to identify organising concepts, contradictions and

similarities. This reduced data was then utilised towards finding key organising concepts which could be put into patterns and themes; the sequence followed that proposed by Crabtree and Miller (1992). The patterns and themes were likened to a research code book which could have been prepared from the conceptual framework in areas where there might have been more knowledge of anticipated findings (Miles and Huberman 1994; Crabtree and Miller 1992). However, at this point I felt that I had not moved beyond the conceptual framework and was being confined by 'early' ideas and not moving towards my goal of finding aspects 'beneath those known to his informants' (Blumer 1978:40).

In order to expand my conceptual framework I reviewed more literature for sensitising concepts that related to the issues arising from the interview topics and the data. During this process I prepared a summary description of each interview, picking up relevant issues to the key concepts and still working with individual transcripts, which had been seen as essential within the Crabtree and Miller sequence - so that each participant's understanding of the concepts was revealed before seeking to make categories across the participants.

I was influenced by Edwards and Ribbens (1998) in their terminology of individual stories arising from the data and I made a brief outline of the individual story from each transcript as a means of looking at the data in a different and comprehensive way. This gave opportunity to see how each individual had 'blended' their work

and showed competing aspects within the context of the individual transcript. Following this, I returned to the Crabtree and Miller (1992) sequence and made comparison across the participants and proposed the ‘analytic categories or theses’ which are developed in the next three chapters. I prepared files of data examples from the participants within each category and used these to describe and interpret the findings. Also, I made a framework/grid, Figure 3, to check that each transcript had made a relevant contribution to the whole as a further evidence to the comprehensiveness of the data.

Figure 3 : Check list for categories and themes in each transcript

CARE & SELF	1	2	3	4 -21 continued
caring				
empathy				
connectedness				
values				
essentialism				
personal & professional				
SCIENCE & EXPERIENCE				
scientific				
knowledge				
up-to-date				
experience universal				
experience linked to knowledge				
SURVEILLANCE				
measurement				
surveillance				
accountable				
nature of health visiting				
self-monitoring				
dilemmas				

These headings for themes within the data reveal how I had begun to group the data within overarching categories, which became the core material with which to

approach a discursive account of the findings through description and interpretation. In addition, to this systematic approach to analysis, I found that writing itself was part of the analytical process that confirmed, or refuted the findings through the text, in which I sought to make explicit the relationships between the variables within the data and the conceptual framework. During this process I found the following comment by Atkinson helpful in confirming that this was a recognised phenomena within qualitative research.

The analytic induction of categories, themes and relationships; the explication of meaning; and the understanding of action may all proceed via the writing itself.... The 'writing up' of the qualitative study is not merely a major and lengthy task; it is *intrinsic* to the 'analysis', the 'theory' and the 'findings'.
(Atkinson 1991:164)

Concluding comment

A comprehensive account of how the research design was accomplished has been discussed. The next three chapters show how I achieved meaning for the data across different categories and themes and utilising feminist concepts. It becomes apparent that health visiting is conducted in two different modes, which can both be understood through feminist explanations for behaviour. It also becomes clear that the managerial context has influence through surveillance for both modes, but these are not necessarily reconciled in practice. Each of these three chapters commences with a theoretical introduction to a particular feminist theory and is followed by evidence to support the analytical debate and the findings. Issues of visibility are

discussed in the analysis, the findings and the development of theory which seeks to make application to practice.

CHAPTER FIVE

CARE BECOMES VISIBLE THROUGH FEMINIST DEBATE

I think it is very difficult to quantify what we actually do, I think because we have such a nebulous sort of job, it is difficult to quantify and difficult to say what we do, and people sort of don't know what you do, or who you are. (Christine)

Introduction

The interest for me in an 'ethic of care' is that it provides a route towards a more prominent place for care in thinking about health care practitioner relations with their clients and could provide a model for the analysis of that care. In health visiting the terms 'care' and 'caring' are not much utilised although it is self evident that health visitor's give 'care'. This will be explored through the participant's views later in the chapter and links with the notion that each of us receives and gives care in particular and general ways throughout our lives, whether as a private individual or a health care practitioner. The assumption being, that each of us has the capacity to *decide* on the degree of care both given and received in many situations and it will be seen that this is also true for health visiting practice. The ethic of care as a practice can incorporate societal, organisational and individual aspects of care, which are also features of the complexity of health visiting.

One of the difficulties in developing the definition and associated concepts of care has been that infant/mothering care has been taken by some as a model for the 'naturalness' of caring by women. Therefore views on care come within that invisible aura ascribed to much womanly activity, without discrimination, as to

whether this is a womanly or a human activity. As a result of taking care 'for-granted' there was little scholarship on this until the 1980s when care was developed as a concept in feminist and nursing literature. It was seen in juxtaposition to women and paid work (Graham 1983); to caring in nursing (Morse et al 1990; Leininger 1984); and as an ethic of care it gained momentum through the second wave of feminism in relation to ethics (Noddings 1984) and was a springboard from the idea that women's development could move in a different way to men's development in morality (Gilligan 1982) and into a feminist ethic of care (Gilligan 1998).

The issues in health visiting which are seen arising from an ethic of care and an analysis of care and care giving, include an acceptance that there are invisible dimensions to the work. These are seen in the data within the concepts of connection and relationality and emotional labour. Secondly that visibility can be made more evident through the application of a care typology, although this tends towards community practice and 'technical care' rather more than individual interaction, although this is not excluded. Thirdly that health visitors are a product of a dominant ideology which places women in a 'caring' role and thus produces a view of self as caring; it is argued that this moves health visiting towards the heart of the dilemma about invisibility and the inability to define core work.

An 'ethic of care' is a way of grouping a cluster of ideas into an entity which assists the description of human activity; it is a concept which covers issues that are

fundamental to human life. The status of 'ethic' suggests it as a guiding principle to be given the same degree of weight as other ways of grouping 'ethics'; as indicated above there is a choice, intrinsic to care giving and receiving, which fits with the view that moral choice is a defining factor in achieving an ethical principle (Tronto 1993:125). It is a contested concept and can be deconstructed in a number of ways across a divide with the two poles, that of 'rights' values and that of 'responsibilities' values. There are a number of relationships which place 'care' with the ethics of rights arguments but the counter argument places it across the 'divide' to the opposite pole where an ethic of care is placed firmly with responsibility. Thus a position which considers there to be 'no rights without responsibility'. These contrasts also contain within them the positions of individualism and societal involvement. The origin for the modern debate rests with Gilligan and her work in respect of dilemmas and decisions about moral choice, and her proposition for a feminist ethic of care contrasted with a feminine ethic of care. It has been advanced into a debate on a societal level which proposes an ethic of care as an analytical and political tool for managing health care (Tronto 1993; Sevenhuijsen 1998).

This chapter will introduce the ethic of care as a tool which can accommodate societal requirements for managing care. In particular it will identify a typology of care and make explicit four phases of instrumental care. Following this it will display the crucial comparison of an ethics of care and an ethics of rights which led to the distinction between the feminine ethic of care and the feminist ethic of care. The

importance of clarity between the old and the new paradigm for women is identified from these two positions and the notion of transformation is indicated. Having set the scene, the data is examined against key concepts and provides evidence that health visitors give both care and emotional labour to their clients. Finally some of the dilemmas of the caring self will be explored and applied against this discussion. It will be seen that the analytical framework has allowed some of the less visible aspects of health visiting to be made more transparent in a new way.

1 FEMINIST ETHIC OF CARE : the debate

1 . 1 A vocabulary to bring ‘care’ into focus

Health visitors do not generally speak of ‘care’, but they have practises and values which appear within the paradigm of care, they also have practices which do not appear visible and for which they need a language - a way to ‘think care’, in which they could be credited with cognitive, reflective and moral practice (Sevenhuijsen 1998:32). A major contribution by Sevenhuijsen is the idea of a moral vocabulary, which could assist in the systematic description of the ethics of care, and be applied in the analysis and evaluation of social problems. One of her key thrusts is the recognition of varieties of social practices, which should lead to care being seen in more flexible ways and less as a fixed pattern. In turn this should lead to a reduction in care being linked to the division of roles; it also would expand the frame from reliance upon the care-giver experience and motivation, to inclusion of relating social practices to the ethics of care and Government policy (Sevenhuijsen 1998:27).

Towards the end of the chapter the discussion incorporates emotional literacy (Morton-Cooper 2000) and a language for emotional labour (Smith 1992) which are further indicators that a vocabulary and language is needed to foreground care in a new way.

A key theme within the debate is how to expose the binary oppositions which are inherent in care; it can be seen from the discussion that by naming 'care' as a social practice it becomes open to new questions and directions, which are hidden in assumptions which frequently surround the word 'care'. One way of examining this has been to identify central values in the ethics of care in language which shows their human activity. From a postmodern point of view Sevenhuijsen considers a feminist ethics of care as a 'postmodern form of humanism' (1998:26) 'finding its sources of inspiration in social practices and virtue-ethics' (1998:151). The central values have been named as attentiveness, responsibility, competence, responsiveness (Sevenhuijsen 1998:61,70) and were named as elements of an ethic of care by Tronto (1993:127-136). Each of these could be illuminated both in theory and as standards for practice within a framework as a means of making care visible in health visiting.

1 . 2 Practice becomes visible through the new vocabulary

A significant feature of the ethics of care, which makes it different from other 'ethics' is that it has been seen as a practice rather than an abstract principle. The

proposition of 'practice' or 'activity' as a defining feature illuminates the central issue of responsibility and its relationship to political endeavour and the collective nature of care, because it is visible and linked into the care-giving policies of the legislature. It also draws with it the individual enactment of caring in private or professional life, although this must be seen in the context of the social situation and the work situation. Further, by definition and analysis of being a practice, it sheds light on the previously hidden relationship of 'caring' within the binary division of men's and women's roles. The taken-for-granted view that women 'would care' within the dominant patriarchal society has been challenged and altered to give a non-gendered possibility for managing care and therefore also provides women with a different set of relationships in the 'care' situation. The developing feminist view is that a feminist ethics should be 'based on a responsiveness to others and a respect for the particular which leads to moral concerns connected to providing care, preventing harm and maintaining relationships' (McNay 1992:92).

Secondly care has been analysed into four phases under the key concept of 'caring' to support understanding of the practice of care (Fisher and Tronto 1990:40-46; Tronto 1993:105-108; Sevenhuijsen 1998:83-86). The four phases identified in the process of caring are, 'caring about', 'taking care of', 'care-giving' and 'care receiving'. Under a deconstruction of the binary position the first two would be attributed to the male power base, best illuminated by identifying the position of women in the 'care-giving' and 'care-receiving' roles. In these two positions

women are over represented, greatly responsible and frequently without power to change the political situation in which the care is given.

The moral context of care assumes for an individual that they will act as a morally good person by interacting with care requirements and for a moral society that it will provide adequate care. For health visiting this links both individual activity and organisational and strategic policy directions. As an ethic, Tronto (1993 :126) comments that her statements about an ethic of care appear somewhat ‘vague and ambiguous’ which she attributes to its nature as ‘practice’ not ‘rule’, in which the language appears to allow for different outcomes in caring, that is it permits failure as well as success. I take this to mean that the moral imperative of a practice rather than a set of rules, has to allow for individual fallibility, which is distinct from a principle or rule which would guide moral intentional behaviour. However there needs to be specific moral qualities which can accommodate the complexity of specific care and a mind-set towards care as part of the moral life of the individual practitioner.

1 . 3 The abstract becoming visible

A decade earlier a contrast for the ethics of care was made with the ethics of rights through the research and critique of moral development by Gilligan (1982:163-168), who approached the ethic of care from a more individual basis than social care, in ways which have located it as a crucial development to the understanding of women’s lives (McNay 1992; Tronto 1993:78; Sevenhuijsen 1998: 50-53). The

critique by Gilligan was based in her view of gender bias in the work of Kohlberg on psychology and moral development; the position of an ethic of care provides a contrast with the morality of justice. The polarities of an ethic of care and an ethic of rights is illustrated in the following table, which also shows the different moral concepts involved in each development.

Ethics of Care (based in Gilligan) responsibilities and relationships	rather than	Ethics of Rights (based in Kohlberg) rules and rights
morality is bound to concrete situations	rather than	morality is formal and abstract
morality is best expressed as an activity - the ‘activity of care’	rather than	morality is best expressed as a set of principles - can be followed
Central question how to deal with dependency and responsibility	differs radically from	that of rights ethics: what are the highest normative principles and rights in situations of moral conflict

(adapted from Tronto 1993:79; Sevenhuijsen 1998:107)

The pole position of an ethic of justice and its basis in rights and rules is displayed here and challenged by the suggestion that women have a different developmental trajectory and are more concerned with responsibility and relationships which is demonstrated in concrete action (Gilligan 1982 : 163,164). The analysis of the data places the participants views within the ethics of care as described here by Gilligan, particularly through responsibilities and relationships. The essentialist argument

about the ‘automatic’ place of the woman in care and situations of care is dealt with through the wider context of the debate.

1 . 4 Transformation to a new and visible paradigm

Although there has been fierce debate over the accuracy and implications of the assertions by Gilligan, it has nevertheless contributed a great deal to feminist thinking about women’s ‘ways of being’ and their differences from men (Larrabee 1993; McNay 1992; Tong 1998). In later discussion the difference between a ‘feminine ethic of care’ and a ‘feminist ethic of care’ has been elaborated by Gilligan (1998:342). The feminine ethic of care being seen as the old paradigm, based in a patriarchal hierarchy of justice which anticipated selfless behaviour as ‘natural and inevitable, necessary and good’. and associated with the ‘ethic of special obligations and interpersonal relations’. This included an apparent isolation from the possibility of personal autonomy for women within the ethic of justice and obligation. The transformation of thinking, from women as inevitable carers to people having a choice, within the new paradigm of a feminist ethic of care, has achieved the kind of political goal associated with feminist thinking, that is, of exposing ‘the sexism and gender-blindness in moral philosophy in order to give space to the moral considerations of women’ (Sevenhuijsen 1998:34). In health visiting there is no debate on these issues to identify which paradigm health visitors are associated with -

either privately and personally or in their role as health care practitioners. This will be explored later in the chapter and in the conclusion to the thesis.

2 HEALTH VISITING WITHIN A FEMINIST ETHIC OF CARE

Introduction

There are three elements within the feminist ethic of care which are relevant to the analysis in this chapter and which provide a way to viewing issues important to the health visitors in the research. These elements are that connection is central to women's ways of being; that there are counter-discourses to care within the new paradigm and the place of the caring self, the selfless - selfish debate which is integral to the ethic of care debate and is also a feature of vocational professions. The themes from the data are that the health visiting relationship can be seen as connection and relationality, which incorporates the view of care and caring about; from which application to practice can be made through the new paradigm to link with responsibilities and relationships.

2 . 1 Connection and relationality as invisible threads in health visiting

There appears to be a link between connection, care and responsibility which can be seen through the health visitor commentaries and in the literature which develops connection and the feminist ethic of care. These issues are linked together in the following comment from Gilligan's argument

A feminist ethic of care begins with connection, theorised as primary and seen as fundamental in human life...Theorising connection as primary and fundamental in human life directs attention to a growing body of supporting evidence which cannot be incorporated within the old paradigm.
(Gilligan 1998: 342,343)

The assertion by Gilligan that connection is primary and fundamental has been developed by a number of theorists within different dimensions of feminism, and as such they contribute the weight and evidence towards the new paradigm which she suggests is evident (Sevenhuijsen 1998: 61; Tong 1998:296,297; Ferguson 1988: 70). The argument presented for connection and relationality appears deeply important to health visiting and views expressed in the data show a network for health visitors and clients which could be seen as a relational web (Shrewsbury 1998; Griffiths 1995). In nursing, the importance of connection is seen in relation to caring which is viewed as primary in the following statement 'This enabling condition of connection and concern is another way in which caring is primary' (Benner and Wrubel 2001:172). Connection is shown in the following extracts from the transcripts and it is argued here that this links with the health visiting relationship, which might be considered as 'primary' for health visitors. The first extract is from Cynthia. Although Cynthia has experienced a variety of organisational changes she has not changed her geographical area of working, which has given her contact with more than one generation of families. This appears to be a source of pleasure for both her and the clients when they meet up with new infants.

I've had more or less the same caseload for many years - I'm easily into the next generation ... I often run into new grannies and I'll say to them 'how's such and such?' or 'what happened to so and so?' And they're quite tickled that I should have remembered something from years ago - you relate back. I have a much more long term view - so yes, relationships end, there's a gap and then they start up again. I mean I've got some wonderful continuity with families. (Cynthia)

Continuity of contact and maintenance of 'the relationship' has been a strong dimension in health visiting where relationships are 'guarded' throughout as if fragile, and are not ended but are left open. Responsibility for establishing and maintaining a working relationship in difficult situations has been seen as important by health visitors and as a way of ensuring future access (Chalmers 1994:179) and as 'enabling and mediating' towards building 'clients' goodwill towards the service' (De la Cuesta 1994:457). Both these researchers have identified the health visitor relationship as a means to an end, fundamentally a working relationship, with no hint of a personal or care based connection.

The relationship is also contrary to other 'relationship' based practices, for example in counselling where a relationship is made and ended (BAC 2000) and in social work where visiting and contact is for a specified time. Health visiting may be more similar to that established by general practitioners where the doctor-patient relationship extends over a time span and is left open between contacts. However, the doctor-patient relationship may be broken by either party as it is based in a formal contracting arrangement which is linked to general practitioner payment for specific people identified on their caseload. In health visiting the relationship is not formally

contracted with the client but is indirectly contracted on the client's behalf through the employer-practitioner contract. There may be natural cessation in the relationship between health visitor and client, but this is also firmly resisted as inevitable by participants in the study. Two examples show this. In the interview with Julie I asked how relationships in health visiting were ended. Her reply quite clearly resisted this as a possibility.

What do you mean ending? Well, I don't think we do really in the majority of cases, because we can't end ... they always know where to find us. (Julie)

Julie was in her second job as a health visitor within a different city, and had been qualified for approximately six years. Thus she was experienced and clear about health visiting issues. A similar sentiment was expressed by Lindsay, who had been a health visitor for eight years. After she had discussed the kind of relationship she seeks to establish with clients, I asked about ending relationships and whether she had a particular way of closing down a relationship. I followed this by summarising with a comment that she had 'a system, a kind of strategy that works to that ending?' The extract shows that she extended her answer to incorporate the connection as an ongoing relationship.

A lot disappear spontaneously in that housing problems are solved, the child recovers from an illness, or learns to be potty trained, starts sleeping through the night, so the problem that they were seeking help with resolves... I try to say 'The baby is doing well ...would you like me to come again or would you prefer to contact me?'

We don't as a social worker would say 'I'm closing the case, now we won't have any contact'... we would leave the door open for them to approach us again if they felt they needed to... It is different from social work. It is different from the General Practitioner... I think health visiting is slightly different. (Lindsay)

Lindsay appeared to gradually work herself towards the view that because of the nature of health visiting the relationship was never formally closed but remained dormant. Continuity of 'care' appears demonstrated, without the necessity of contact, but as a door always open. In this situation the metaphor of 'invisible' is apposite for the relationship and connection. A similar view was inferred by Wendy when she was describing the nature of health visiting and what happened when a child reached school age.

... if you - if you've got a family and suddenly the child becomes five, erm, and you may have given that mother a lot of support, you can't suddenly withdraw that support, so you would take on the role of just seeing the mother. (Wendy)

It could appear as though there is little forward planning to make different arrangements for such a woman or any expectation that the relationship would be ended. This thesis suggests that unclosed relationships are part of the invisible aura that pervades health visiting and that this means that a network of connections is in place which can become 'live' and visible at any time. The research suggests that the women in this study did see themselves as part of an ongoing web or network and it is suggested that this would largely be invisible unless activated into a work contact.

Women's connectedness with each other is seen as central to their experience and as a way of incorporating the private and public aspects of their lives in a relational way Ferguson (1988). Of particular interest to this discussion is Ferguson's 'codes of

need and relation' (1988:69) in which women's connectedness with each other is seen as central to their experience, and that experience can thereby reveal positive attributes and a positive combination of public and private life. In the study, the health visitors appeared to meet a relational need in the way they drew on their own experiences to make intersubjective connections with their clients or explicitly focused on the woman and her needs. This will be developed more fully in the next chapter when the epistemological relationship of knowledge and experience is considered. It will also be touched upon again at the end of this chapter. Examples from two health visitors will suffice here.

I think the common thing is with post natal depression when you're actually visiting and the purpose of your visit is focusing on the woman ... it's often linked with self esteem being low. It's no good just giving medication and sending someone away, you've got to help them actually to cope with life and so it's very much feminine issues really. You know, she has rights and needs as well [as her partner] (Rosemary)

And they do seem to listen quite intently and you know we have quite an exchange of experiences, which they seem as if they get something from it [talking about an experience of an acute illness as the focus of the visit] (Deidre)

A further way of characterising connection and relationality has been through the metaphor of web (Shrewsbury 1998; Griffiths 1995). The statement by Shrewsbury needs to be considered in this context, 'Women seek to build connections. They seek to maintain connections that have been built. Relationships are more than a set of interactions among people. They are the web of existence.' (1998:169). The above discussion and extracts from the data demonstrate the connection and

relational aspects of health visiting which this thesis argues is part of caring, but hidden in the web within which the health visitor works.

2.2 Health visiting as an activity of care

Lindsay was the only health visitor to use the term ‘caring’ as a frame for her work. She had been discussing tension between the ‘contact driven’ service and ‘quality’, in a way which was reminiscent of the work by Traynor and Wade (1994) when they reported upon the morale of nurses and health visitors working in the community. One of the health visitors in their study was reported as saying ‘Money has replaced the patient in our focus of care. We need to resist this insidious erosion to our commitment to people.’ and another ‘More emphasis appears to be put on clerical and computer work, with far less time for patients/clients’ (1994:43). In the interview with Lindsay she had identified her own very difficult childbirth experience and I had asked how her personal awareness of women’s needs after a difficult childbirth experience would be managed in view of the pressure for more contacts in the time available. I asked whether her own experience would influence the amount of time she would give clients with this kind of birth history. Her response was positive and linked into the former role as a nurse and showed a determination to provide a ‘quality’ service even if there were accounting difficulties to face at a later time. Thus her personal experience had an effect upon her view of health care practice.

I think the caring person, the nursing person, within us, I would say personally, yes. I would sit there and give her the time she needs and cope with the consequences at the end of the year, or whatever, the end of the month. (Lindsay)

There is no doubt that she saw this to be the responsible action in the context of quality of her work and expressed a challenge to the employing authority if the system of working to contact numbers did reduce the quality of work. Also her own private experience had given an added insight to the needs of a particular woman she had described in order to illustrate the issue. The core values of care, identified earlier, namely, attentiveness, responsibility, competence and responsiveness appear to be exhibited.

Since the terms care and caring are not utilised to describe their work the next section will examine how the health visitor's responses to discussion about their work can be seen within an analytical framework which has informed the debate on 'caring' and the ethics of care (Sevenhuijsen 1998:83-86; Tronto 1993:105-108; Fisher and Tronto 1990:40-46). The four phases in the framework are 'caring about', 'taking care of', 'care-giving' and 'care-receiving'; put into table form enables the boundaries and some of the associated qualities to be seen clearly. In the debate these are analytically separate although interconnected through overlaps and relational dimensions which are apparent in different ways through the phases. Evidence from the data will be used to illustrate each of the phases.

‘Caring about’ paying attention to the factors which determine survival and well being
seeing and recognising care needs is crucial
knowledge of particular situations is important
is not conditional on love or connection
to do with understanding needs
to do with selecting means and choosing categories for action
is culturally and individually shaped
can be seen at a social and political level to describe society’s
approach to homelessness etc.

‘Taking care of’ means taking responsibility for initiating caring activities
it demands more sustained effort and detailed knowledge of particular situations than ‘caring about’
main qualities needed are empathy and judgement
involves notions of agency and responsibility
seeing what is necessary in a particular situation and which means can be brought into action
to do with meeting unmet needs

‘Care-giving’ involves direct meeting of needs for care
is concrete work with care-givers in direct contact with the objects of care
carrying out daily routines
developing a thorough understanding of the daily routines

‘Care-receiving’ includes the reaction of those towards whom care is directed
attention to the reactions is important for the quality process
identifies whether or not care needs have been met
also for the motivation of those who care

(adapted from Fisher and Tronto 1990:40-46)

2.2.1 ‘caring about’

In the research there were a number of opportunities to identify features of health visiting through the responses, some of which were in direct reply to a question on its nature, others were in relation to activities being described. Within the phase ‘caring about’ are issues which can be described as an overview of events and

prioritisation involving skills and qualities of assessment from a macro perspective.

Wendy gives a broad goal which encompasses this

Well it (health visiting) is ensuring that an appropriate service is offered to clients with a particular GP practice, that is appropriate to their needs and to enable each child to reach its full potential. Erm and at the same time empowering the parents or carers of that child to actually get the service that they want in fact, so that it meets their needs. (Wendy)

Health visiting is seen to be an individualised activity set within the context of a service which should be prepared to recognise and meet care needs, currently identified through profiling of a community and utilising a social model of health (Billings 1996). An example of the kind of macro view of community care from a social and political stance is given by Grace in her view of health visiting and the need to address teenage pregnancies.

I think what we do need is more drop-in clinics for teenagers at GP surgeries ... we've been thinking of trying something like that ... setting up something for fifteen year olds ... because if we could get people taking responsibility for their own life early on, we may stop some unplanned pregnancies. (Grace)

This is an issue that could be described as 'caring about' and which also incorporates an executive strategy based on need as well as the individualised response. These two extracts are typical of how health visitors approach their work from a strategic and societal position, which exemplify the features noted under the typology for 'caring about' and which are visible aspects of health visiting.

2.2.2 'taking care of'

The second phase of the care framework moves from the recognition of need to the activity of finding ways to meet the need, possibly through indirect means such as volunteers and co-ordinating others to implement specific solutions to perceived unmet need. There remains a political tension with respect to the allocation of funds and agreement that an individual practitioner could utilise their time in what might be innovative and new activity - a point made by Lindsay. She was engaged in some innovative work through planned activities with young mothers and appeared to demonstrate the qualities of empathy, judgement, agency and responsibility which are features of the phase 'taking care of'. She used her professional judgement to identify and meet the need for self esteem in new mothers and spoke of her persistence to maintain activities when colleagues criticised the way she utilised her health visiting time.

... because I haven't got as high a birth rate as my colleagues, I can set up other groups, and have done so. But I've been told that if my contacts fall then those groups will 'go by the board'. I have got a post-natal group that I've now run for three years which has really snowballed and it does very well. It's a group which we call 'Parent's Time Out' and it's for first time mum's only, because we haven't the facilities for toddlers running around and all the implications that come with that. It's doing very well, it's looking at reducing post-natal depression, and enhancing their coping strategies and enabling them to have time out for themselves and set up support for each other. It has really done very well; this year particularly there are too many really... I set it up three times a year... and it will run for twelve to thirteen weeks. (Lindsay)

Lindsay was clear in her objectives for the group and had worked hard to liaise with local colleges for some sessions, for example the Women's Health Course and

arranged for their students to undertake a beauty treatment with the women in the group. She had also enlisted volunteers and nursery nurses to support leisure activities such as swimming. Lindsay and the General Practitioner had identified positive outcomes. For example that the contacts made by the first time mothers to the GP had dropped and also that the accident figures in young children had fallen.

It would appear that this kind of health visiting intervention fulfils a need identified for family support to be more pro-active and systematic in the work with families where needs are evident (Audit Commission 1994). Particular mention was made for families where there was low confidence, low self esteem and depression (1994:125). However some colleagues did not perceive health visiting in this way and the local managers, apparently, had never asked for outcomes or evaluations. It did need stamina and persistence, the kinds of qualities identified within the phase of 'taking care of', attributes which were not always acknowledged by colleagues. In the research no-one spoke against this kind of activity but there did seem to be local points of tension in health visiting care, from a contracting managerial perspective and from a practitioner colleague perspective.

But some of our colleagues don't understand what we are doing and feel that we are just wasting our time... some of our colleagues think we are just having an afternoon off, you know, I suppose when some people see us taking off mums to a beauty treatment they might think we should be doing something better... although it's going easy now, it's hard work. You do have to chase it... you've got to get them in for the first couple of sessions and sometimes it's really demoralising...sometimes my colleague and I will be cursing, thinking 'I don't know why I bother - you know- (Lindsay)

There are many examples nationally of this kind of ground breaking work which identifies need and does something about it, and that fulfils challenges from the Audit commission findings for more obvious outcomes from health visitor interventions. Examples include for example Newpin, 45 Cope Street, Nottingham and Pen Green, Corby (Audit Commission: 40-42). It would appear that the reason 'they bother' is because they care about their clients in many different ways. In another example of innovative work, Adamson et al (1997:14) also had to face scepticism from some colleagues for their more open access kind of work; this suggests that this type of 'caring' activity is individually conceived and acted upon. It does not appear to be core work although applauded by national overseers such as the Audit Commission. For many, the difficulty from a practitioner perspective is that they are dependent upon the employer for time and space for 'taking care of' activities which may be perceived as taking time from the more traditional health surveillance role of the health visitor which has been contracted by health care purchasers. Although visible as an activity, this kind of health visiting work is hidden within individual enterprise, rather than being identified as core work through the typology of 'caring about' the population. It appears as peripheral, idiosyncratic and vulnerable to restriction if 'more important' targets are not met.

2.2.3 'care giving'

The third phase in this analytical framework of care, includes the direct meeting of needs - 'care-giving', which needs defining in respect of health visiting. Health

visitors would not normally consider their work to be 'direct care' as indicated in this phase of 'care giving' but it will be argued here that, nevertheless, this is a legitimate interpretation in this context. A typology of Helping Strategies (Hopson 1978) introduced a four stage model which separated 'direct care' from advice giving, teaching, and counselling within work situations including nursing. For the purposes of this analysis it is proposed that all four elements are utilised for 'care-giving' in health visiting since health visiting incorporates all these dimensions and is not a single entity (Obeid and McGee 1996). The principle embodied, at this point in the analytical framework, is that there is immediacy in relationship between the care-giver and the recipient and a full comprehension of the detail of the daily needs. Carolyn gives an example where the visible and direct care of immunisation may compete with the less visible aspect of behaviour management. It is also evident that both activities are 'care-giving' not 'taking care of' within the context of the typology.

I think the types of things I want to do are less liked because it's less possible to identify measures. We're finding it difficult to put them into a criteria, you know. It does work you know (sleep management course for toddlers). I see it over and over again. If you offer a course of management, you know, over six or eight weeks, you have these wonderful results at the end ... an effect on other kinds of problems during the day - like potty training, all kinds of things. (Carolyn)

Carolyn is demonstrating a great enthusiasm for the work she undertakes in behaviour management of toddlers, and has clearly moved from the 'taking care of' phase, which would have included all the work of identifying unmet needs and taking responsibility for setting up the opportunity to give direct care. Her ability to

facilitate change through direct contact with the carers is made possible through her 'understanding of the daily routines' of parenthood. However, there is a sub text which is her concern that the care-giving which is visible and clearly measured is the one which is valued by her managers and offers the most for her own job security. This appears to jeopardise work which is less visible. The thesis argues for a framework which shows how the power base which identifies care needs must also facilitate their relief, even if the means are not easily measurable and are less visible than some of the work. This typology of care can be seen to offer a way of revealing the complexity in health visiting.

2.2.4 'care receiving'

As the final loop in this framework, the view of the recipient of care is essential to evaluate questions of accuracy in the identification of need and to complete a quality of care sequence (Tronto 1993:108). Over the years there has been some evidence that health visitors' perception of needs met and fulfilled have been different from the recipient (Kendall 1991; Mayall 1990). In this research the health visitors linked the relationship of support and the resultant demand by clients as a positive sign of meeting need. In discussing this, Susan appears to measure client satisfaction by the continued contact from the client.

One lady in particular comes in, not every week, in tears, but does come in quite frequently, comes in here because she's upset for whatever reason. And obviously she finds some support in coming in here to speak to me, because otherwise she wouldn't come in and she wouldn't come back each time.
(Susan)

A not dissimilar view was given by Greta, when discussing the nature of health visiting. She talked about the two way nature of the work. The way in which a client had sufficient confidence to seek out the health visitor, which within this care framework could be adjudged as the care-receiver reaction to the care-giver or care-giving activity.

So it's a two way thing isn't it. I feel. Rather than perhaps just one-way. About relationships - being seen in the area. People seeing that you've helped so-and-so down the road, 'so maybe she's all right then'. So they feel you're part of the fixtures and fittings and eventually they come to see you. Perhaps they wouldn't have done when you first started. That sort of thing I suppose. So it isn't just a one-way thing in your approach to them. It's about, erm, the confidence they gain in you. (Greta)

These are not scientific ways of measuring client satisfaction, but the client seeking out the health visitor appears to be the rule-of-thumb used by practitioners to gauge whether or not they are meeting individual needs. What this does not do is evaluate whether the services provided through macro planning under the heading of 'caring about' and 'taking care of' are those most needed by the client. It would be possible through the data recording system to record the numbers who seek out the health visitor rather than being the recipients of health visitor initiative through planned activity. Thus the typology of care has shown a mechanism and a vocabulary for making more explicit an understanding of care in health visiting. It supports the notion of portraying care as 'an activity of care' from Gilligan's analysis of an ethic

of care and gives some answer to the central question of dependency and responsibility as instrumental to care and not as inevitable due to gender.

3 COUNTER DISCOURSES TO CARE AND VISIBILITY

Introduction

As indicated earlier in the chapter, there are discourses which polarise and perpetuate the binary division and which develop a feminine ethic of care within the context of an ethic of justice. For the purposes of this analysis the normative position of science is seen in the 'unaware' stance of the ethic of justice and the invisible place of women and their activities' perhaps best summed up in the essentialist debate. Within the research there were references to this way of thinking by the health visitors, although there were also evidences of struggle and tension in respect of normative thinking, as seen in the drive to empower and produce more independence in young women.

3.1 Essentialism

Essentialism is the view that 'we are as we are' because of the 'essential' nature of our being, 'the conviction that men are men and women are women and that there is no way to change either's nature' (Tong 1998:88). Criticisms of Gilligan suggest that her views lead towards an essentialist position (McNay 1992) although there remains much debate. As Larrabee (1993:16) states '... at this marking of a decade of responses to Gilligan's original *Voice* we find we have more questions than answers.' Current discourses strongly refute essentialism through postmodern

debates on the reduction of fixed patterns of identities and the fragmentary nature of individual roles (Davies B. 1997b) but there were views from the participants which cannot be ignored. In discussion with the health visitors in the study there were tensions around the nature of women and men, which also had some impact on the nature of health visiting. There were some 'blinkered' views by health visitors, which suggested a lack of knowledge about the possible arguments in this arena. At one extreme was Cynthia who recognised herself as having a stereotypical view, which showed her in an essentialist position.

.. in the relationship with my own husband, he will often say 'oh, you're a girl and I'm a man' so you know - end of story - He's saying 'I'm not interested in that bit [of the story]... Although men go into the nursing profession, and they become parents, I don't think their sense of caring and nurturing is the same as a woman's. And I still have this stereotype that nurses should be female. (Cynthia)

Other health visitors expressed their views in the context of child care and of work.

But I think, I suppose in child care, most people look to women for support don't they, women in the family for support. I mean if you say 'You're going back to work, who's looking after them?' It's always a sister or an aunt or a mother. It's never an uncle or granddad (Deidre)

In a different example of essentialism, Margaret accepted that men were caring and would be within the 'caring professions', but that men and women had different relationships with their children. She also felt that there were differences between men and women in their relationships with their children.

I think there are men who make very good nurses, just as there are men who make good counsellors, make very good social workers, and men who make very good primary teachers... So I think as long as we are aware of the cultural side, I think there will always be men who go into the caring side when choosing professions...

I mean the relationship that a mother has with a child is quite different anyway to the relationship a father has with a child... From the men I have spoken to I don't think the feeling is quite the same. (Margaret)

With men as health visitors there is an impact of essentialist thinking that can affect how the work is conducted. Not all the health visitors had worked with a male health visitor, but those who had found that at times they needed to be a mediator for practice as the next example shows.

And I said, 'I thought you were a little bit down, have you discussed it with Alan?' And she said 'No, I'm not able to because he's a man. He wouldn't understand'. I sort of said, 'he's a nurse you know and a health visitor. And she said 'Well even so, men don't understand, my husband doesn't, my doctor doesn't...' I said to her I'd have a word with him... and she came back afterwards and said 'oh, he is nice, isn't he?'... she put on a good show when she saw him. He was perfect. (Grace)

There had been particular relationship difficulties for this client with her husband and father and it was Grace's view that the male health visitor was a great help to the client. It appeared as though the essentialist stereotype needed to be overcome by personal intervention by the female health visitor before the therapeutic aspect of the work could be developed. This demonstrates how health visitors, and clients, subscribe, albeit in unaware ways, to the dominant hegemonic ideology, and are interacting in the old feminine paradigm.

3.2 Counter-discourses to care - the pull to masculinist views of visible caring

From an individual stance there is a binary of selfishness and selflessness, in which the gendered view of women's behaviour would place her as selfish when acting in a

contrary manner to the old paradigm (Gilligan 1998). A problem when moving from one world view to a new world view is the period of transition in which both paradigms are operative because there is a site of struggle for interpretation and values. For example in the issue to do with selfishness, when both men and women believe that the central behaviour for women is pleasing others and meeting their needs in a caring way, anyone with a contrary view from the old paradigm would be seen as selfish. By contrast, Gilligan (1998) reported that moving towards the new paradigm gave women a voice and empowered them to resist the patriarchal expectations of selfless caring.

In the new paradigm, the feminist ethic of care is placed within discourses of relationship and is associated with the emergence of a voice through psychological dissociation from the past and is based in fundamental connection with others. So much so, that Gilligan suggests that women have given up relationship within the patriarchal context of justice in order to establish other more fruitful relationships. She goes as far as stating that the feminist ethic of care 'became the voice of the resistance' (1998:342), which can be seen in individual behaviour and by extrapolation in individual health visiting activity. A different dimension for change is seen through the links with social transformations in the context of feminism and transformative practice based in experience (Lewis 1993: 4-5) which to some extent is seen in the health visitor examples below. Issues of transformation and transitions

will be developed more fully in the next chapter, which has as its focus the ways in which knowledge and experience can produce change in outlook and practice.

For an interpretation of health care practice this view of an ethic of care shows a relationship between the individual taking responsibility and the organisational and social aspects of meeting needs. In the study there were some health visitors who wanted to develop women's independence which it is argued would uphold the new paradigm of resisting patriarchal expectations and is seen moving towards an individual stance. Several health visitors used the term 'empower' in the sense of giving information and expecting the client to act upon that; however there were others who appeared to go further than this and appeared to describe behaviour that could be seen in relation to a voice and to the feminist ethic of care. For example Sylvia who was a lone parent, drew on her own experience as a resource, whereas Grace gave a social value for her view for the development of young women.

I suppose because I deal with so many females, I'm very much education oriented in my thinking - these people may be on their own all of their lives - they may need to find a quality of life. So I try, especially to get the teenagers back into school... I say to them 'You pick up the paper and you look' It doesn't have to be an educational course, it can be a course for them to start getting their self esteem, getting themselves valued. I think that it is so important because it reflects on the children in the long term; if the mum hasn't got it, she can't pass it on. I feel strong in myself and I try to pass this strength onto girls, women, whatever you might call them... 'you can do it'... I think for them to be fulfilled is so important. (Sylvia)

I've got a few teenage mums at the present time. They're the ones that I keep sort of trying to sort of get them to go back to do some sort of qualification. They must think I'm really horrible because I say, 'well, your child's coming up to 18 months or 2 years old now, what are you going to do with yourself? What future?' (Grace)

These examples show individual work, motivated by care to meet needs for self development of young women and can be seen as fulfilling a similar function to that described earlier in the typology of ‘taking care of’ and the innovative work described by Lindsay. The difficulty of making this process and emphasis visible as an aspect of care remains an ongoing difficulty for health visiting. The next section considers how an alternative analysis, of emotional labour, could give a context for the way in which care is hidden, although of itself it does not provide a means of making it more visible, except through the introduction of terminology and a language.

4 EMOTIONAL LABOUR AND THE CARING SELF

Introduction

In the world of vocation and the needs of patients and clients there is regularly a subtext of ‘self sacrifice’ in respect of activities like working longer hours than were planned in order to meet patient and client needs. This also links in with the polarities of selfishness and selflessness that are part of the binary system, that in unaware ways seeks to take as norm the male view point and places a female position against this, so that care and caring are seen as the epitomy of women’s work. The binary system was seen as polarities within the feminist ethic of care discussion and pervades much of the way that women’s work is perceived by both men and women through the unaware stance from the dominant values and belief systems.

4.1 Invisible work

A theme throughout the literature has been the invisibility of health visiting work in discussion with practitioners as well as those who endeavour to account for the work. One health visitor used the term ‘nebulous’ quoted at the head of this chapter and Lindsay used the term ‘invisible’ when she was discussing the relative value of male and female health visitors.

Health visiting is invisible whether it is done by a man or a woman. It’s so non specific in many areas, a lot of medical professionals and even doctors really don’t know what health visitors do, even now! (Lindsay)

Within feminist literature there is a long history of debate about the nature of women’s work as invisible (Hoschild 1983; Graham 1983; Fisher and Tronto 1990; James 1992; Edwards and Ribbens 1998) and the place of work being private. A further development of this has located an intermediate domain that is part way between the private and the public, and applied to child care between mothers and others, including the health visitor (Mayall 1993:77,78). Lack of being ‘understood or valued’ was a consistent concern for health visitors, found by Traynor and Wade (1994:59). Recently, within an anthropological study, health visiting has been declared as invisible because of the difficulty in classifying the outcomes of much of the work (Littlewood 2000 : 599).

The suggestion within this thesis is that health visiting remains invisible because the values of attentiveness, responsibility, competence and responsiveness found within the caring paradigm are applied on an individual basis but not converted to outcomes in referrals or other forms of measurement recognised by the recording systems. Lack of coding systems for care and caring activities has been seen as a feature of emotional labour (James 1989; Smith and Gray 2000). Emotional labour has its basis in those activities which are to do with the regulation of feelings and has been discussed in a number of ways since its initial conceptualisation by Hoschild. For example it can be seen as the suppression of personal feeling in order to facilitate a sense of being cared for in another person (Hoschild 1983). Building on this, the labour involved in dealing with other people's feelings was likened to work as in physical labour (James 1993) and therefore resulted in exacting a toll on the practitioner.

In nursing it involves the nurse-patient interactions which give 'feelings of care and support that nurses are constantly called upon to instil in their patients' (Smith and Gray 2000:7). Finally it has also been said to provide a language which could describe the tacit skills of care (Smith 1992); providing a language was one of the advantages of the typology of care suggested earlier in the chapter. The participants in the study demonstrated the features of emotional labour in various ways and will be illustrated below. But by having no means to codify this aspect of emotional work it both remains unaccounted for adequately, and is also not available to be developed

as a resource within the NHS (Smith and Gray 2000) and remains invisible but is experienced as real work by the practitioner.

An example of unplanned and often invisible work occurs when individuals seek help at the health centre and require someone to support and deal with their feelings. Sometimes being seen by a health visitor who happens to be in the office, as took place in the example given by Rosemary.

... and she wanted to talk to somebody because she felt quite desperate about her child's behaviour. This was how she presented... he wouldn't do this and he wouldn't do that, and she looked very tired and erm I said, 'do you ever get a break?' And she - that's when her eyes filled and she said 'well, my mum used to, but my mum died suddenly a few weeks back.' (Rosemary)

The nature of the organisational structure allows this unexpected and unanticipated kind of activity, which is based in caring and empathy. However, the coding activity might indicate 'bereavement topic' but without any indication of the personal skill which elicited the real problem and the emotional labour in supporting an unknown client without any prior knowledge that this demand was imminent. As well as this dimension for others, there is also the need for the health visitor to deal with her own feelings. This is both in the 'labouring' sense of utilising personal resources, seen in the extract from Rosemary, but also in concealing distress or other inappropriate negative feeling that the situation may have triggered. An example from Gail shows this in a stark fashion.

I remember once actually talking to somebody very soon after my own bereavement. She'd actually just lost her baby. And I was sitting outside and just listening to it all, erm of what she'd gone through... such as she couldn't bear to go to the grave of her baby because she felt that the ground was cold. And actually getting back into the car and bursting into tears (Gail)

A different kind of example is provided by Greta when she describes the interplay of feelings aroused in her as a mother, and how the feelings had to be displaced in order to do her job as a health care practitioner.

Unfortunately you have to make a distinction between feeling as you would, as - as any mother would, and then as a professional. Only last week I had to make that distinction in my own mind - where does support start and end - and then your own responsibility - where your own feelings come into play and then when you're professional. It's boundaries. It's talking about your own emotions, isn't it, and where they begin and stop? (Greta)

An interesting theme about emotional literacy is developed by Morton-Cooper and Palmer (2000) as a contribution to the debate about emotional labour and the need for awareness of emotions which are experienced during the practice of health care. This contributes further to the need for a language to convey and value the emotional content of the work, which was demonstrated throughout this study, but remained largely unaccounted for and thus contributed to the metaphor of invisibility. These extracts provide evidence that emotional labour is integral to health visiting and appears to fit within the whole context of care and caring as a normative position.

4.2 The caring self - a dilemma for health visiting?

The way these concepts are demonstrated makes it appear as though the selfless model of care is the most natural and preferred, which I have argued is the unaware state of the feminine ethic of care, the normative view of women (Skeggs 1997 : 67-70). It is also perceived as part of health care practice as is shown by Shirley who put the achievement of health surveillance above her own needs to be off duty at the normal hour.

... I explained how accurate they (the scales and measures) were in the surgery, and that this could make a big difference. So I think it's - yes, giving reasons, even if it meant staying after five o'clock for their convenience.
(Shirley)

Selflessness was seen as 'crucial to their production of their caring selves' in the study by Skeggs (1997:65) of women who were enrolled on a 'caring' course. The argument presented by Skeggs asserts that this selflessness, 'to be a caring self is a gendered disposition' (1997:64). The health visitors in the study did not purport to be developing as caring people nor does this thesis argue for that. However the argument is that they appeared to fulfil many of the dimensions of the qualities of a caring person, in a not dissimilar way to the women in Skeggs' study. The debate suggests two meanings within a definition of caring - caring *about* and caring *for* within a disposition which epitomises feminine duty. As such it fits with the earlier debate about a feminine ethic of care and does not reveal any link with a feminist ethic of care. This is also true for other ways of examining emotional labour, for example in the finding of 'alertness to the needs of others' coined by Staden (1998) in her study with enrolled nurses and the emotional labour of caring.

At a deeper level and in relation to a feminist analysis of care there are issues here to do with the fundamental nature of health visiting and its difficulty in focusing on a core work. All the health visitors in the study were a product of their 'heritage' in that there is a cultural norm for women to care and they practised within the 'wider discourses of how women should be' (Skeggs 1997:69). They were also all nurses, as a pre-requisite of their health visitor education and as such had been socialised into a 'caring' profession, thus fulfilling the blend of experience and knowledge that creates a predisposition to care and be responsible within an epistemological framework (Probyn 1993).

Conclusion

The thesis moves to a position of arguing that the 'feeling' caring part of health visiting is bound up with the concept of self as a cultural outcome and product of the perceived feminine duty. This chapter has shown how a number of different analyses can be applied to the caring work of health visitors. My own phrase is that the data has revealed a caring-relational dimension to health visiting, which is largely hidden in its activity. I have proposed a number of ways in which it could be made more visible and will discuss further in the conclusion what the implications are for health visiting in the future. The dilemma appears to be how to strengthen and utilise and make visible the caring aspect or how to reduce it so that it no longer has power to

demoralise the ‘caring’ practitioner who feels under threat and devalued in the modern context of transparency, value for money and evidence-based practice.

CHAPTER 6

FEMINIST VIEWS ON KNOWLEDGE ARE INVISIBLE IN HEALTH VISITING

I use my personal experience more here than I ever did before; I was very much research based. I'm still research based but a research base isn't the only thing in life, is it? There are, you know, life experiences which are valuable in work and I think a lot of work places now ask for people with lifetime experiences - your experiences can be as valuable as your qualification. (Tracy)

Introduction

Health visiting, although a service delivered mainly to women and through women, has little history of feminist analysis for its practices and development and little formal acknowledgement of the 'street credibility' which can accompany life experiences of child birth and child rearing. That is not to develop an essentialist argument, but it exemplifies the dominance of the scientific approach in health visiting and the various ways in which personal experience has been minimised. The introductory quotation shows a growing recognition of the place of experience that is gained through the lifelong learning movement.

This chapter explores how a feminist lens can shed light onto some of the more invisible aspects of health visiting which are based in experience and contribute as hidden resources but are not themselves measurable. The issues being discussed are feminist theory in epistemology and how it provides a new perspective on the traditional scientific model and how experience can be a valid source of knowledge. The themes are that health visitors utilise experience as a resource in their work and

at the same time have dilemmas and tensions about the suitability and equity of this. This is relevant to the science-experience contribution to knowledge and to the view that where the trajectories of feminism and science intersect, there can be new outlooks. Another set of themes relate to the perceived dilemma between providing an ungendered service or whether a practitioner clearly interacts as male or female. This points to the unaware incorporation of the dominant masculine ideology in which gender is 'taken-for-granted' and which a feminist viewpoint would seek to make visible. The relationship of reflexivity and experience is explored as part of the transformation process. A movement from traditional practice through transformations and transitions towards a new view will be traced in the chapter.

This research with health visitors was influenced by Dorothy Smith, a feminist standpoint theorist, who had what I have termed a 'moment of illumination' when the gendered nature of the academic world became visible to her and influenced her subsequent research.

The intellectual world spread out before me appeared, indeed I experienced it as genderless. But its apparent lack of center was indeed centered. It was structured by its gender subtext. (Smith D. 1987:7)

This seemed to parallel the situation in health visiting - a neutral service where gender did not appear to exist. Although for a service which is made up of more than 98% women workers (UKCC 1999b), visiting mainly women clients, it is surprising that more commentary and research about the possibility of relating to

clients as women and vice versa has not been debated. This thesis aims to make visible some aspects of the gendered structure of health visiting, both from an individual practitioner stance and from an organisational viewpoint in respect of the taken-for-granted assumptions and minimising of personal experiences.

This chapter therefore explores a feminist approach to scientific knowledge and aims to show how experience can be a valid source of knowledge and can make a contribution to the understanding of social reality and the work of health visiting. The argument provided suggests that feminist science is part of the counter culture which seeks to develop a modern science rather than perpetuating traditional science with its androcentric attitude. It will also be argued that feminist theory has already made a contribution to the history and development of knowledge through being applied to the analysis of women's experiences. The discussion will incorporate some of the different views on experience and objectivity relations held in feminism which will in turn be explored and considered with the views of the participants. A view that experience can be seen as central to learning will be developed within the dilemma that it is not generally valued and may be seen as illegitimate in a traditional science paradigm.

Feminism has challenged the dominant position of objective science being the key source of knowledge and has proposed an examination and interpretation of experiences in order to bring a different perspective to commonly viewed situations.

An often quoted example is that of marital rape - it had been experienced by women as heterosexual sex within marriage, but required a new view, a transformed view, about it in order for there to be learning, by both men and women, to define this behaviour as an assault (Harding 1991:123). Experience on its own, as in this example may be insufficient to bring about illumination, but interpreting experiences through different lenses can be extremely productive. Linked to this is the feminist challenge to objectivity as being the only legitimate source of knowledge; this political view of objectivism is also challenged through qualitative research scholars in the debates about truth and positivism (Denzin and Lincoln 1998:8). There needs to be a context to support knowledge development while recognising 'that some situations are worse than others for generating knowledge.' (Harding 1991:278). This is a further way of underlining the need to have a comprehensively different way of utilising experience and real situations as contributors to knowledge.

In the historical development of feminism, Tong (1998) identified eight key perspectives of feminism, each with distinct origins and viewpoints about the nature of feminism and feminist thought. The labels assist as pedagogical tools in revealing differences and as public recognition that feminism incorporates many different views and also that it has been established for long enough to have a history. What Tong does not do is martial the viewpoints into working arguments and applications for ways in which feminism could contribute to world history. In various ways she shows how and why there has been antagonism to feminist thought both within and without

the feminist community. This has led to different viewpoints and applications in feminism and an acknowledgement that there is diversity in feminism, with the concept of 'feminism' itself being a contested term (Harding 1991:6; Olesen 1994:158; Tong 1998:8). A definition which has influenced this analysis is that 'Feminism is a political project with emancipatory aims' (Francis 1999:385); other scholars have incorporated emancipatory aims into their definitions and perspectives (Stanley and Wise 1993; Griffiths 1995); understanding the context and experience of women being oppressed and finding ways to alter and remove this are also motivating factors (Tong 1998). Motivation for this study incorporates the view that there would be impact and change for both health visitors and clients as an outcome or result from the research.

1 TRADITION AND THE COMPLEXITY OF PRACTICE : science and experience

1.1 Conventional epistemology hides women's part in knowledge creation

Health visitor courses, in common with other programmes of study within nursing and midwifery, generally provide a curriculum model for the development of curricula but do not make explicit the basis of knowledge development. It would appear as unnecessary to do so, with a taken-for-granted understanding that would be known by all involved in the discussions. The knowledge base would take-for-

granted the central place of objective science with little debate about a reflexive and subjective dimension to knowledge - although the concept of the reflective practitioner would be present. By contrast, models of practice might be debated and made explicit, for example the educational models of spiral curriculum, process-product interaction and in courses for community health care the tensions between a medical model of health and a social model of health (Elkan et al 2000a). The assumptions about knowledge which underpin curricula are based in conventional epistemology of the scientific basis of knowledge and of a quantitative approach to evidence-based practice. It is argued that this is an incomplete but traditional way of viewing knowledge creation and leads to traditional practice. It will be suggested that a feminist epistemology could contribute new insights to health visitor development and to the practice of health visiting.

Conventional epistemology - the theory of knowledge - carries with it the assumptions of a common world view, a taken-for-granted paradigm which has no need for debate by either the general public, those being educated or those responsible for developing educational programmes. Debate about the nature of knowledge does take place, is concerned with the nature and scope of knowledge, its presuppositions and basis, and the general reliability of claims to knowledge. However this is within what is named by those who have moved into a different view, as the dominant scientific paradigm. Feminist questioning raised within the study of epistemology are 'Who can be subjects, agents of socially legitimate

knowledge?... What kinds of things can be known?' (Harding 1991 : 109). Other questions raised by Harding include those to do with situated knowledge, objectivity and value-neutrality. She proposed that the sources of knowledge are those of the dominant races and classes and the dominant group experiences and thus argues that the white, middle class male is central to the dominant views that pass for a universal agreement about epistemology.

It is argued that curriculum documents do not need to make explicit their epistemological basis because of a corporate understanding held within the scientific paradigm. This in turn influences the theoretical approach to the programmes for students. The divisions are not clear cut in practice between the taken-for-granted position of the science base and the personal and professional experience and reflexivity which may be present in the practitioner. However, as the data will show, the participants did utilise their personal knowledge developed from experience but found it to be a point of tension. In this way they were operating outside the scientific paradigm but without having an alternative paradigm within which to place or categorise their activity. This thesis suggests that given a feminist paradigm for knowledge creation, the health visitors would have a way of valuing the contribution which their professional and personal experience could give to clients. It is further suggested that the lack of commentary about these experiences is a source of 'invisible' practice which the thesis seeks to legitimise.

The following extracts from the data reveal some of the issues raised by the participants that illustrate the tensions within working to a scientific paradigm but where experience impacts and poses an alternative position. Greta had worked as a health visitor for approximately five years, had been an experienced nurse before this and practising as a health visitor for three years in an urban area. She was enrolled on a degree programme and was very keen to undertake research into health visiting. She highlighted the movement between the science base, experience and reflexiveness through a number of comments about her practice. It can be seen that the basis for her work is theoretical in policy and knowledge, but her comments about achieving this reveal the need to be reflexive and personally involved.

We're tackling the Targets for Health and one of my prime objectives for going in to see families is reducing all sorts of target figures. Particularly smoking, alcohol and nutrition. We're talking about underweight girls here, more than ever. Nutrition's very poor. A huge depression rate - every other woman seems to be on Prozac. Community practice nurse services are very limited, particularly for postnatal depression... I keep on trying to improve my communication skills... I feel I'm becoming more erm... critical about erm my approach to different things... perhaps group work... I don't know, just depending on the situation really. (Greta)

Greta then went on to sum up the interplay of training and guidelines as the external expression of knowledge, with standards as a mechanism for utilising that knowledge. But she also draws on experience, with some of its dilemmas, as a source of knowledge. The context was discussion about personal feelings and boundaries in difficult professional situations. It shows the complexity of professional practice in

relation to knowledge creation and managing to create situations where health related changes could take place.

Where your own feelings come into play and then when you are acting as a professional. It's boundaries, it's talking about your own emotions isn't it, where they begin and stop? That comes with professional experience doesn't it? With time you learn to make the right moves at the right time... So many factors and stresses that depend where that person is at, at that precise moment, and where the professional is at that precise moment. But then of course you've got your standards that you have to adhere to, that protect against all that. Child protection guidelines, and your training, your many years of experience and so on. (Greta)

The interplay of experience and science is a key aspect of feminist epistemologies which will be discussed throughout this chapter in order to show how they contribute to knowledge creation developed and valued by women. The scientific aspect of standards and guidelines appear as the dominant values, which would assist in balancing out any tendency to overvalue emotional experience in the job. A different kind of value for the science base was shown by Lindsay when she gave an example of a woman who had an extremely bad experience of childbirth and complications. Lindsay related this to herself and her own experience, but in order to negotiate with the general practitioner for extra support she drew on a scientific article.

...I may well have needed some professional help. So I can really empathise with this woman because I know exactly what she was going through, the flashbacks and what she is going through, this post traumatic stress syndrome. And I said to the doctors last week, 'I suppose you have heard about Mrs such and such' and they said 'yes'. I said I have a good article on this, I have been reading one last month about this shock syndrome, and you have to be prepared, this lady may have some problems. (Lindsay)

The science underpinnings of the course are increasingly important, one reason is that the academic level has moved from a diploma to degree level studies. Another is the climate of evidence-based practice and the need to analyse and problem solve in the way that Lindsay discussed. Not all health visitors commented upon this, but Tracy was able to separate out the pressure for a 'science' which was in the course and the later need to contextualise and personalise it to individual clients. She had been a health visitor for nearly ten years and worked in another urban area.

I did the degree and I did my essays and handed them in and all this sort of thing, but I never actually think I thought during that whole time. There was a very large group of us, all from different backgrounds. You had your deadlines, you worked to the same time, you gathered your information... I think before, you know, you do your health visiting and you learn all your research based stuff, and it's black and it's white and there's no grey... so you're not really applying it to that individual's circumstances and culture and social setting and all this sort of thing. So like your nutrition, you learn your nutrition and you go out and reel it off to the clients. But you know in - in a way, beforehand, you never really look at the context in which they're living. (Tracy)

The interplay of research and the reality of experience was also seen in Tracy's comment which appears at the head of this chapter. She also reveals the complexity of health visiting, which is the need to re-fashion the scientific goals for health into ways which take into account the client perspective. The next chapter reveals some of the criticisms which not doing this has given to health visiting. The next chapter also develops some of the issues which influence practice through employers and systems, and these extracts foreshadow some of that debate - particularly where there is tension between pursuing a government target and where experience

suggests there are inhibiting factors. Some of these issues were also seen in the previous chapter in relation to care and emotional labour.

In order to further develop the debate about the relative importance of science and experience, the next section examines briefly three feminist positions on epistemology with evidence from the data to show that there were issues about knowledge creation raised by the participants.

1.2 Feminisms and epistemology : traditional views of practice come under scrutiny

Arising out of the feminist community there has been the development of a recognisable feminist practice and critique of established practices, which appears to me as an application of a new contribution to world knowledge. The perspectives which have gained general recognition in feminist writings in relation to a critique of epistemology are feminist empiricism, feminist standpoint and feminist postmodern thought, attributed as models most clearly developed by Harding (Hawkesworth 1989:535; Stanley and Wise 1993:190). These three approaches remain separate and are partially conflicting in their views, but they are significant as '*distinctively feminist analyses of theories of scientific knowledge*' (Harding 1991:48). The objects within this discussion are the nature of science, feminist science and the establishment of a relationship between experience and knowledge. The tensions within the different feminist views can be used creatively as tools in different ways to

keep the feminist project moving forward (Francis 1999) as transformations and transitions take place in the way that women contribute new perspectives in knowledge and practice.

1.2.1 Feminist empiricism

Feminist empiricism, based in philosophical realism concentrates upon traditional methodology and makes an assertion, perhaps an assumption, that sexism and androcentrism as identifiable biases are the results of poor science. Adherents of this view believe that these biases could be reduced or removed by more rigorous procedures, which would achieve objective results that would not disadvantage women and women's experiences (Olesen 1998). Also, the intersubjectivity between researcher and participant, which is a feature of feminist research does not have a place in traditional methodology. A difficulty with the view that suggests more rigour will clarify women's views, is that without a transformed view of what women's perspectives are, the empirical data will tend to replicate the dominant position or give an uncritical and unaware analysis. An example of the difficulty of giving a 'view from inside' from within my own experience of community nurse education has been the difficulty in exploring the role of the health visitor with district nurses and other nurses who are not health visitors. Giving an overview of the need for child health surveillance including the 'shadow' side of child protection, appears relatively straightforward when linked to Government policy and local guidelines. However trying to expand upon the complexity of individual assessment and the

varieties of intensity with respect to interventions, which was noted earlier in this chapter, have seemed baffling to those whose work is dominated by more clear cut assessments and interventions. Other than a stereotypical view it has been difficult to create the kind of internal view which comes from socialisation into a different kind of health care practice. This difficulty in making visible the complexity to other people and of not being able to provide an authoritative basis that is clear, has in turn created barriers in working together in primary health care (Littlewood, 2000; Kichbusch, 1989). Perhaps it is a truism to say 'how do you know what you don't know!' and yet it will become apparent that this was true for some of the participants even in respect of what becoming a mother meant when personal knowledge replaced or added to the professional knowledge.

I was very aware that I didn't have my own children, but I thought I was very sympathetic and understanding - you know - about sleeplessness and erm 24 hours a day... I - I felt I understood and that I was very kind and understanding... but it wasn't until I had my own children that I really understood what it was all about... the incredible tiredness and the amazing, erm, responsibility you have. And I was so shocked because I thought they fed for an hour then they slept for three hours, so the shock for me... so that for me was a huge learning experience for me... Well if I was shocked and I'd been a health visitor, what must it be like for most mums?... So my own experiences of being a mother has obviously affected how I work, yes.
(Carolyn)

But that is to move ahead too rapidly before considering the explanations about the source of knowledge and the limitations of knowledge. The critical issue for feminism is summed up by Harding in the way in which she turns 'objectivity' on its head by declaring it to be a totally biased view based upon the dominant group

perspective. That is the male view, and the traditionally scientific way of developing knowledge.

Feminism needs sciences that are more objective than the knowledge-seeking practices of androcentric, bourgeois groups in the West which have been passed off as objective, dispassionate, disinterested, universal science.
(Harding 1991 : 307)

Expressed in a different way, but picking up a similar challenge to the dominant position are the views of Stanley and Wise (1993) in which they highlight the ontological aspect of knowledge and see it in opposition to traditional epistemology. By placing this within the context of reflexivity they keep the focus on the internal processes of knowledge creation and have justified their term of a ‘symbiotic relationship’ between ontology and epistemology.

Proclamation of the reflexivity of feminist research processes; acknowledgement of the contextual specificity of feminist as of all other knowledge; recognition that who a researcher is, in terms of their sex, race, class and sexuality, affects what they ‘find’ in research is as true for feminist as any other researchers: these and other components of feminist epistemology emphasise the *necessarily* ontological basis of knowledge-production. This is one of the most profoundly radical of feminist statements, for it mounts a fundamental challenge to the basic precepts of Cartesian epistemology. (Stanley and Wise 1993:228, italics in original)

This rather long quotation is included in full to show the weight and due regard that must be given to the internal processes. The argument is made, that unless an individual scientist is able to ‘see’ from a different viewpoint, there will be no movement forward in respect of the feminist understandings.

Within health visiting there is a difficulty in locating the place of personal experience and in locating a research methodology which could accommodate experience as 'objective knowledge' in the way that has just been discussed. The general public would anticipate that personal experience of child rearing would enhance knowledge, but it is not given credit by the health visitor. This thesis is arguing for the position that personal experience, as well as professional experiences, are of value because they enrich the knowledge base of the 'scientific' health visitor and provide an alternative approach to women clients that is 'personal and womanly' as distinct from a service which is gender free. Secondly, by having a legitimate framework for the expression of this kind of experience, it would provide a way of making this aspect of health visiting more visible, which at present is a hidden resource in health visiting. Sandra, a fairly experienced health visitor, with a young family, exhibits the dichotomy in her comment.

I hate myself for saying this, but one thing which amazes me, is as a health visitor, that I have more street cred for having children. And while I don't think that's justified at all, women listen if they feel you've been there, done that, and have some personal experience, umm, and I think the same comes in terms of gender. (Sandra)

The socialisation of distance from her own experience is present in this statement, coupled with a sense of surprise, which I assume to be the outcomes of the educational and socialisation process within health visiting. Sandra appears to express a view point of conventional objectivity being necessary to do the job and by implication also necessary to fulfil a research stance. Sandra discredits the worth of

her own experience, which is both a factual situation and an interpretation. A brief comment from Julie shows how experience can be downgraded.

So, I think, yes, it's just experience I suppose. (Julie)

Although feminist empiricism may undertake research into women's experience, including health visiting, there will be limited intersubjectivity and little exploration of the way in which there might be oppression or the need for an altered perception about this.

1.2.2 Feminist standpoint

Feminist standpoint, based in historical and social materialism considers the problem to be much more extensive than a methodological problem - and rejects the notion of an 'unmediated' pure knowledge, asserting that knowledge (and the notion of truth) is always mediated through a particular position or reality. The goal is to incorporate feminist theory and the feminist political struggle into research which includes research from women's lives as providing a more complete description of reality (Olesen 1994). The feminist standpoint theorists conclude that knowledge is socially situated and that feminist standpoint researchers will identify specific social values and political issues in women's situations as resources for investigation. In this way, the standpoint empirical and theoretical explanations will be different from the

feminist empiricist model of research by incorporating, or privileging, women's stance on particular issues and research problems. (Smith D. 1987; Harding 1987; 1991; Hartsock 1997; Stanley and Wise 1993). This is with a view to enhancing an alternative view to that unaware and dominant lens which both the general public and health care practitioners utilise in their assessments of situations and which results in some work remaining invisible. It brings into the foreground specific issues that may previously have been invisible, or rendered so, by the context and the 'blinkered' outlooks that are prevalent through education and socialisation.

In the research, a number of health visitors revealed unconscious contradictions about their role as women, revealing a dilemma about interacting in a personal dimension or providing a service that was gender free. The context from which the next extract comes, was a question about the place of men in health visiting.

I have had a short time of experience actually during my training because there was a male health visitor where I - for a time, where I - he'd just qualified when I trained. Fine, no problem. I can understand that possibly a woman may not - a lady may not want a male health visitor. I can sort of see - if I had a male health visitor, I don't think I'd have any problem with that. Erm, (pause) and as a professional I don't see any problem. I don't think it's any different to a woman - no different at all. (Susan)

Susan was one of the less experienced health visitors, but was an experienced community nurse with an honours degree in community nursing; she was also a mother of a young family. Thus she had considerable background to draw on for her views. This view which puts forward the 'professional' stance, appears to illustrate

the neutral, genderless viewpoint spoken of by Dorothy Smith and to be an exemplar of the unquestioning and unaware stance of the dominant culture within health visiting and the NHS and its requirements. Another example on this from the data is from a more experienced health visitor, who also had a degree and a family. We were discussing men in health visiting and she supported the view that clients gave positive feedback about the one or two male health visitors who had been in that area. However, she also asserted that there was no difference in health visiting abilities between the men and women and contributed to the gender blindness theme by making reference to the health visitor or the health visiting skills as being 'it'.

...I don't think there's any difference between a man or a woman in the role of health visitor. Erm, I think the threads of health visiting and sort of building the relationship with the client, the skills should be there, whether *it's* a male or a female. (Sonia, my emphasis)

Sonia's rationale for this assertion was that the man may have had personal family experience of children or a partner breast feeding and other similar activities. However, also of interest, is that Sonia then talked about role models in health visiting and the way in which some clients looked for the 'motherly type' of health visitor.

I know that there's clients that... would prefer an older person coming to talk to them. They're looking for a mother type. Erm, and , erm, I have a colleague that fits into that remit and she's very motherly; I mean that's one of the qualities she comes out with and some clients actively seek a mother type of image in the health visitor. (Sonia)

Standpoint research and analysis can provide an alternative view to the traditional view which is that this is a service being conducted in a neutral way by exposing, as these statements show, that there has been gender loss or gender dilution in the conduct and practice of health visiting. Therefore the experience of women as the workers has not been valued and by implication neither have the clients been seen as fully functioning women, with stresses that occur by their particular situations as women, such as domestic violence and lone parent hood and prostitution (Peckover 1999; Frost 1999; Knott and Latter 1999; Lazenbatt et al 1999). In this way, research and knowledge creation from a feminist standpoint can privilege women and their needs. It can contribute feminist science to health visitor literature and practice and demonstrate that there is a relationship between experience and knowledge.

1.2.3 Feminist postmodernism

Feminist postmodernism, rejects the possibility of ‘a truth’, considers the previous two approaches insufficiently radical and too focused on ‘one truth’. It proposes a plurality of views which take account of the ‘situatedness’ of each observer/researcher (Harding 1991:48; Hawkesworth 1989 : 536). The crux of the debate is that a different view or definition of objectivity is proposed.

I would like a doctrine of embodied objectivity that accommodates paradoxical and critical feminist science projects : Feminist objectivity means quite simply *situated knowledges*. (Haraway 1988 : 581, emphasis in original)

Haraway developed a critique in respect of traditional epistemologies and objectivity because she viewed them as providing insufficient explanation for what she named as 'transcendental' knowledge, a view from 'nowhere' that was in reality the dominant view, and with no reference to being located in a particular context. Her argument is partly about location and partly about current activity. From this she proposed the possibility of objective knowledge being both active and located; this is then defined as '*situated knowledge*'. In the study, the health visitors seemed to wrestle with how to categorise and utilise their experiences as part of their knowledge development, while insisting that it was not necessary for every health visitor to have the same experiences. The following comment by Rosemary is typical of the points of view expressed

And experiences - you don't use them as such, but they're obviously there in your make-up and your personality. Your experience, you can't shut it away when you're at work, can you - so it - my coping strategies that I've learned for myself ... helped me formulate coping strategies for families. Well, they helped to link, you know, having been there. But I wouldn't say it's necessary for health visiting practice to go through those things that I've been through, but nevertheless because I've been through them, they make a difference. (Rosemary)

This is another evidence of contradiction in the personal management of knowledge and values. Here there is awareness that a tension was being expressed about an experience which could be utilised as a resource although not necessarily as a legitimate resource. Rosemary was an experienced health visitor, was currently studying for a Masters' degree, was married and had a variety of life experiences which she discussed but appeared to have no model for incorporating these. It is

suggested that this colludes with the invisibility metaphor by not knowing how to utilise experience in practice, appearing not to have a language or a voice to articulate these in an equal woman to woman way in a professional setting. A traditional view in feminism is that women's voices have been silenced (Gilligan 1982; Blackmore 1990) by the dominant voices and that facilitating their expression is part of the political and the practical emancipation of women. Postmodernism has reached beyond this to propose that until there is articulation the view 'does not exist' (Griffiths 1995) and further that there is always a plurality or multiple truths to be heard. The potential for knowledge creation can be seen here through the articulation of dilemmas, which also reveal the nature of health visiting and the way in which undesirable elements of health visiting - drawing on experience could be made invisible by a cloak of silence.

2.0 TRANSFORMATIONS AND VISIBILITY : where trajectories of feminism and science intersect

2.1 Transformation in outlook can bring new perspectives into view

Harding suggested that new feminist ways of seeing knowledge are most visible where the trajectories of transformed knowledge intersect, that is of a feminist transformed logic and science transformed logic (Harding 1991 : 307). A transformed logic of science is one that is undergoing change and moving to a different position in outlook. In educational terms this has been seen as the need to

transform 'meaning perspectives' through a critical re-evaluation of the 'epistemic, sociocultural, and psychic distortions acquired through the process of introjection, the uncritical acceptance of another's values' (Mezirow 1990 : 14). Having accepted that the basis of knowledge and science in the Western world is not objective, but that it is made visible through the lens of the dominant groups, that is the ruling classes of white males, then it is part of the transformative process of knowledge-seeking to want the application of different lenses to enhance visibility of different facets of social reality. In this way the logic for a feminist emancipatory project can be given a context and considered as a series of transformations.

In addressing the assumptions underpinning conventional science, Harding (1991:308) identified four features which need making visible in order for transformations to take place:-

- the place of politics
- the contradictory nature of social forces which both advance and also tend to 'pull back to' previous positions
- 'the observer and the observed to be on the same causal plane' so that there is a cycle of informing and being informed by the same perspectives
- the disciplinary tradition which tends to hold a narrow focus which is based in the past

These features will be used to provide a framework for examining the data in respect of transformations in health visitors. These ideas have not been developed in the health visiting literature, but the research data showed health visitors who were reflexive and questioning about the political nature of their work and their situation.

Also, there was evidence of transformation through the personal and professional experiences gained, which in some instances was a radical alteration from the expectation gained through the traditional curriculum.

2.1.1 Politics and the need to see differently

Among the participants, Gail was perhaps the most aware and tended to question and challenge variously the nature of the work she did. This may have been partly an outcome of her educational background, since she was one of the few with both a bachelor and a masters' degree, or there may have been other, personal features, which I did not elucidate, that contributed to her more reflexive stance. In this example it was work she was required to undertake in health education with elderly people.

I - I there's an expectation that I - I need to kind of show people, you know, what healthy eating is, smoking and issues like that. Erm, but on the same line, here are people who actually don't want to be the worried well. And maybe they don't even want to come for screening. And in a way looking at life and death in a different view. I thought, 'what trigger am I playing in people's lives?' (Gail)

The conventional science which underpins public health and health visiting assumes that health screening and health education are for the individual 'good', The Health of the Nation (Great Britain, DOH 1992) and that this is a rationale for continued development of the 'service' of health visiting. Thus 'experts' identify targets for health and the employees have the responsibility for achieving the health related

changes within individuals and populations to meet the targets. It is easy to see, from this perspective, how health visiting could be a neutral and gender free service until or unless there is personal questioning which sees the client in a different way. It would appear that health visitors, at this point, align themselves with 'the expert' target setting groups, that they then provide advice to clients, and seek to meet health targets within the client group. This could be viewed as the more visible aspect of health visiting with links to public health work and the scientific study of disease patterns and prevention. What happens, then, to the less visible and less scientific aspect of health visiting, which is raised in the kind of questioning and possible doubt, raised by Gail? This is discussed later in the chapter as part of the transitional processes, when it is also apparent that others have faced these dilemmas.

Different positions of health visitors in respect of 'science' and of 'experience' are considered in the next sections where the strength of the 'scientific web' is seen through the pressures to utilise recognised external authorities for the work. In turn this scientific construct, as the basis for work, receives internal pressure through experience for modification. The discussion will identify some of the key transforming events which are involved when there are contradictory processes in practice.

2.1.2 The push and pull of social forces as transforming activities

In the study, the health visitors were not speaking to theoretical positions, but nevertheless revealed the kind of intersection described by Harding in respect of a changed outlook when personal experience intersected with professional knowledge. Also when personal experience intersected with theoretical knowledge. Common examples were personal bereavement and having one's own children and the transformation this gave to outlook and potential interaction with clients. Margaret mentioned both of these personal examples in her comments about the relationship between experience and work and is quite clear that these have been transforming events that impacted upon her health visiting practice.

I found going back, having had my own children gives you an insight into how young mothers cope and the things they go through, sleepless nights and that sort of thing! And the death of my father, I hadn't experienced a family bereavement until then. Obviously you do have a lot to do with bereavement in the job, but as an outsider, really - it didn't become a personal thing until we looked after him. But you feel as if the experience you can draw on for that is going to be valuable. Certainly if you were dealing with any coping situation after a bereavement, if I was involved with that, I feel I would be able to deal with that better, having dealt with that myself.
(Margaret)

During the hundred years of health visiting there have been social changes which have contributed to different kinds of insight, not least the numbers of women with families who are currently in the workforce, including health visitors. Secondly, the range of work has expanded to include elderly people with health education needs. It

will be seen that others also utilised their experience to move themselves into a different position in health visiting, while others expressed dilemmas in relation to personal experience and knowledge. One of the dilemma's voiced seemed to be in knowing how to utilise experience for their clients, including the experience which could be contributed by virtue of age - being a younger or older practitioner as will be seen in the next extract from the data. Each practitioner has a contribution to make, but there appeared tension where neither was seen to make a satisfactory contribution to the client on the basis of their current situated experience. However, there is an implicit recognition in the following extract from the study, that personal experience is utilised in the practice of health visiting.

I mean you can't put old heads on young shoulders, but it does work both ways, in that a lot of the younger health visitors have recently had young children themselves and are more up-to-date with the equipment that is available and the networks that young mums can link into... A lot of people say 'Hum, how can she know what she's doing if she's never had children?'... And then you get a more mature member of staff and they say 'well, she's too old to know what is happening these days!' (Joyce)

Neither the social forces of age nor the experience of motherhood were viewed as satisfactory in this extract - it seems to imply that there is resistance to health visiting, whatever the background. Resistance to health visiting has been a social force which has constantly exerted pressure and which has not been adequately explained (Dingwall et al 1988; Symonds 1991; Stone 1996; Davies C. 1997), but will be explored in some detail in the next chapter. Thus transformations may encounter a 'pull back' through historical legacy, which here carries some negative aspects.

Nevertheless the issue of experience and its function as a transforming activity does take place in health visiting and the extract in the next section continues in a similar way to that given by Margaret, but takes it further.

2.1.3 The same plane of experience provides opportunity for a new view

The need to be aligned on the same plane is part of the intersubjectivity of feminist research and is seen as a way of developing a more open and visible view of the experiences being researched and the subsequent knowledge produced. In health visiting, it is argued here that being on the same plane is a way of revealing views that have previously been hidden. Christine spoke about how her experience had transformed her understanding and influenced her practice. In fact, she begins to align herself with being a mother and the whole ‘mothering’ experience. This clearly had a profound impact upon her health visiting and she raises questions about the validity of the ‘scientific’ position, but is still caught up in the scientific web, which is indicated in the comment ‘by the book’.

...I don't think you have to experience something to have it [skill and understanding]. But having said that, I now have much more perception I'm sure, of what it is like to have a child crying all night, or whatever the problem be, more understanding of the demands of children. But also in another way more ‘laid back’ in as much as I think, yes you can have a certain amount of worries and concerns about them, but they are going to change and you are going to exchange them for another set of problems... I suppose I have become more ‘laid back’ maybe not so much ‘by the book’ as I would have been in the past. (Christine)

The issue of the link between knowledge and experience was clearly of some significance to Christine, because she also raised it in relation to bereavement and how this had affected her ability to understand the traumatic aspects of grief.

I recently had a friend whose partner died suddenly, I hadn't really I suppose, with bereavement lived through it with anybody before and I found there was a lot I didn't know. (Christine)

She expanded upon this at some length and it was clear that this, as well as mothering, were transformative events leading to that intersection of knowledge and experience described earlier in the chapter. It is also argued here, that many of the examples in this chapter, although used in different sections are revealing the same kind of phenomena. A more personal example was given by Julie and it also reveals the emotional labour which can accompany work with women.

... and I had a miscarriage which I felt quite hard, and I think it has made me see things that people are going through in a different way, I suppose. When people have had miscarriages and things, you are sympathetic towards them, but you don't understand what it's like. So things like that, I think have affected the way I look at things. But part of you, sort of, you can understand people more, and part of me has got to almost distance myself from situations to be able to cope with it. (Julie)

The next section picks up the feature of altering the 'retrospective focus as the view' as a way of revealing that transformation has taken place. It is acknowledged that experience can be a source of misrepresentation, (Harding 1991) but this should not

be used to inhibit the production of new ways of seeing and managing health care practice.

2.1.4 Alter the retrospective focus as the view and provide a different view

The thesis being developed is that experience alters the known view, which for health visiting has originally been provided through the scientific curriculum. Increasingly the curriculum emphasises reflective practice, with a critical incident used to develop a reflective cycle which incorporates experience and changed practice. However, it is argued here that this may not be a ‘transforming’ event if it continues to uphold the dominant view unless it in some way mitigated against the unaware stance which has just been discussed. The crux appears to be a need to develop understandings which contribute to liberatory social needs as seen in achieving feminist goals of awareness, alongside other countercultures who support the same endeavours in counterbalancing the traditional androcentric and dominant perspectives (Ferguson 1986:68; Harding 1991:308; Lather 1991:86). Gail, who was mentioned as being one of the most reflexive health visitors, also commented in the most explicit way about reflection and supervision. In this extract she had been speaking of different models of working and the need for setting objectives to give a direction with clients. She also spoke of the need for clinical supervision which would actually include supervision of practice for what is regarded as an invisible activity because of being within a client home.

I think clinical supervision would be overseeing erm actual practice on a face to face contact with clients or groups or families and offering reflective practice and opportunities for improvement of practice. Erm along with looking at record keeping as well. So the two are inter-twined because it's no good just looking at records, you've actually got to see them doing to match up. Are they consistent? Is there objective setting? Is the client made aware of the objective setting? Is the evaluation of the process accurate or does it bear any resemblance to what somebody from the outside is seeing... this privacy sometimes needs to be broken through erm, to help health visitors move on... It's not like wound care which you can see, erm it's something invisible within a home setting. (Gail)

Further discussion on the nature of knowledge creation through the interplay of these feminist epistemologies are seen to support the potential for change. Evidences of transitional thinking in the health visitors in the study is developed in the next section.

3.0 TRANSITIONS AND EXPERIENCE : making visible health visiting

3.1 Experience and subjectivity are instrumental in transitions

This section discusses the way in which experience and practice can be located within a transitional period. This is fuelled by the view that feminism has evoked a transitional period for men and women in the way that tradition is being questioned. For example in countercultures of minority groups such as men and women of colour (Harding 1991) through applications such as a cultural analysis model for curriculum (Lawton 1983) or in less obvious areas such as sports science where the application of a cultural analysis is entirely relevant (Ingham and Hardy 1993).

Women's experience has been seen as a core concern in feminist research, for both the feminist empiricist and feminist standpoint epistemologies because of the

previous exclusion or distortions of women's reality in traditional objective research (Blackmore 1999). Experience is also central to feminist politics by its basis in social transformation and its ability to reveal subordination and strength (Lewis 1993). This section develops the argument that there is a transitional process of experience which contributes to the transformation that can occur within individual health visitors in which stereotypical views are reduced. The thesis suggests that health visiting could be transformed collectively if the transitions which appear as a natural development were valued and proposed as part of the norm in learning about the job. This in turn would provide a different kind of 'service' to the women as clients. (Peckover 1999; Frost 1999; Orr 1986) From a postmodern position the centrality of women's experience in feminist discourse, and the uncertainty which women express in relation to the value of their own subjective experience is evident (Blackmore 1995; Lewis 1993).

A crucial question from Blackmore in her argument against the male transcendental position, noted earlier by Haraway as the opposite to situated knowledge, is 'what is a truer account than the subject's own account? (Blackmore 1999 : 65). This is a controversial statement in respect of the objective/subjective binary divide; it picks up the theme from Haraway on 'situated knowledge' as a way of achieving a position which is both contextualized, provides a valid account of social reality and challenges the transcendental position. It also links with the assertion by Harding in

which she rejects knowledge claims that appear to have been separated from the social reality in which the knowledge was created.

If human knowledge is not in some complex way grounded in human lives and human experience, what is the source of its status in modern Western societies? (Harding 1991: 271)

The following extract is a typical example of how the health visitors acknowledged their experience *and* saw it as pertinent to their work and *yet* were guarded in how they saw its value and therefore in how it contributed to the broad spectrum of human knowledge as described by Harding. Gail had been describing her turmoil at returning to work when she had a young infant.

And I think if - you shouldn't bring your own experience into play - but sometimes examples like that do help mothers to cope a little more and relate to the person that's trying to help them with coping strategies - they think 'oh, she's been through it, she knows what I'm talking about. (Gail)

This statement brings the issues back to earlier comments, which is that personal and private experiences are undervalued in the conventional epistemologies used in health visiting. Also that a feminist epistemological base could be developed in the curriculum to show how experience, by both the client and the health visitor are crucial in acknowledging the ontological position, which in turn will affect the beliefs and values in how the work is conducted. A transformation from a conventional outlook to that of applying a feminist lens might enable health visitors

to see a different set of needs in the women they visit. For example, Susan was rather diffident about the place of experience in her working life. She seemed not to want to use the word 'experience' for the situation she described, which had been a set of rather difficult circumstances that left her struggling in a number of ways. It was as though she had no mechanism, model or lens to accommodate her experience and knowledge.

Interviewer : I wonder how you feel about visiting women who are struggling?

I don't know whether it makes you any better at the job, I don't think it does particularly, but I think certainly you can understand how they are feeling, possibly. I mean I don't know that. It's like people who haven't got children, doing health visiting. I don't think it make you any better, it's the experience you gain on the job. But I think the erm... the erm... whatever you want to call it, but the process I went through when I first had my child certainly gives you that little bit of insight into how people are possibly feeling. Does that make sense?... I don't know if I visit any more or do anything different to my colleagues. I don't think so. But I do all... I'm always very conscious of that period of time that was a factor in the way I was. (Susan)

These extracts from the data show how personal experiences were instrumental in the way that Gail and Susan approached their work, as has also been shown in many other places in discussing the data. It is argued here that these are transitions which could result in resources from which other women might benefit. It was also noted in the previous chapter when discussing emotional labour that these were potential resources not utilised in nursing. To achieve a greater level of awareness about the way in which relating to women clients could be different and more effective, would

involve a curriculum development. This might be hard to accomplish with the close interactions with the NHS and the professional bodies in the curriculum who uphold the dominant and masculinist positions of gendered organisations (Davies C. 1997; Symonds 1991). A call for an urgent policy and educational change in respect of domestic violence was made by Peckover (1998). This will be discussed in detail in the conclusion and will seek to show the advantages that this could have to client needs.

3.2 Taken-for-granted views are questioned

For health visitors the view of the NHS being perceived as masculinist (Davies C. 1997; Symonds 1991), through the dominant structures and perspectives, would be a new and possibly uncomfortable insight to what had been a taken-for-granted relationship. In addition the suggestion that their individual perception of women's needs was partial and influenced by the dominant knowledge about what constitutes family life might also be highly disquieting. In some measure this was seen in the responses to the Audit Commission (1994) where there was criticism about the lack of targeted and transparent work with families who had a high level of deprivation (Cohen 1994).

The issue of how experience is used as data in contributing to knowledge has been seen in different ways by significant feminist scholars and researchers. From standpoint theory it is the 'view from women's lives' which is the significant factor,

not the experiences on their own, Harding (1991:269). This remains consistent with standpoint theories in which the positioning of the onlooker, as on a cusp, can see both the androcentric position with its interpretation and an alternative analysis based in women's knowledge and experience. Some of the health visitors in the study revealed that they had undergone a change in attitude and expectation after qualifying, giving more credence to the needs of the client and less to the accomplishment of changed lives through achieving targets set by the NHS. Greta gave a particularly honest example of this when we were discussing self-monitoring and development.

When I first came here - inside I would feel annoyed if people didn't comply. But of course, and perhaps that would come across. I don't know. Erm, but certainly, some years on, you feel 'well why should they comply?' you know. Erm, it's entirely up to them and that's fine. So I feel more relaxed about people that don't want to take up the service... Erm and I mean that even when there are problems, I still feel it's their right, unless you know, so we've just got to find different ways of making it acceptable (Greta)

The slight caveat of caution, given at the end was a reference back to a comment she had made a few minutes earlier when describing a difficult situation of a dilemma, caring and boundaries when faced with a child who was not receiving adequate care.

The personal side of doing the job is raised here, and the dilemma of being a vehicle for state intervention when a child is at risk (Westlake and Pearson 1997). In educational terms the debate about preparation for practice and the theory - practice divide could be debated from a conventional scientific viewpoint. From a feminist

view on curriculum, these issues could be addressed as inevitable tensions within a gendered organisation where the gendered nature of the work is evidenced. Maureen identifies similar themes to Greta in her comments that reveal a need to see situations from the context of the client and not to impose a standard viewpoint.

Well, I suppose the first thing you learn on the job very rapidly is realism. Because when you've finished the course, you have a very idealistic view of what health visiting can do and achieve and what you are going to do with this tool that you've just got, and how you're going to change the world... You learn to be non judgmental - you may have been a bit judgmental to start with, but you do actually get better at that. You get better at accepting that people have rights - to refuse and rights to erm change their minds and the rights to have their say about things... its got to be a consultation procedure. (Maureen)

This section has shown health visitor perceptions and expectations changing and it is argued here that this could be used as professional development to show experience and knowledge working together to provide a new view of the work. The example of marital rape was given earlier and serves to illustrate how once a transformation has taken place to give a different perception, the new knowledge could be incorporated into a curriculum as a 'new science'. When viewed from an androcentric position, the dominant position had created an unaware and uncontested view about this behaviour. It was not perceived as 'an optional experience' until a feminist analysis was applied to reveal a different interpretation of that event. This also illustrates the way in which an analytical framework can change understanding of women's experiences, giving a different picture of their social reality rather than

what could be described as a partial and distorted view produced by the dominant group (Blackmore 1999: 65,66; Harding 1991 : 287; Hekman 1997 : 362). However it is also noted that new perceptions can also bring a cost and that it can be with considerable personal pain that individual women gain an awareness of the distortions of belief and truth with which they have been accustomed to view 'the normal' situations (Blackmore 1999:65,66; Harding 1991: 287). Legislation and local guidelines support the continuing professional development of health visitors for child protection but it is of concern that health visitors are said to be 'blinkered' in their awareness of domestic violence to women (Frost 1999) and less than helpful with single unsupported mothers (Knott and Latter 1999), but with little evidence of in service education in these areas. The final section explores the evidence that some health visitors did recognise the contribution of experience as a resource although still without a model to aid its application in practice.

3.3 Experience as a universal teacher : exposure to practice as a transition and a way to a new perspective

The place of women as 'knower's' has been another core dimension to women as participants and also women as researchers and deemed as '*the* basis of feminist methodology' (Olesen 1994 : 159). This was illustrated by Olesen from research in the women's health movement reaching back to the late 1970s. The source of knowledge continues to be a central concern in the 1990s and is integral to current debates about experience and subjectivity, contrasted with the 'more "objective"

forms of knowledge (e.g. the sciences)' Blackmore (1999 : 65). It is possible to consider the experience of women's silence in this debate as contributing to the difficulty which women have faced in becoming visible as sources of legitimate knowledge.

Women's experience of silence is seen as a central feature of their existence in a theme about the personal, the private and the public, in which Lewis (1993:13) utilised metaphor and story to bring about a fusion of the private with the public 'to uncover the politics of personal experience and to give these personal experiences social meaning' (Lewis 1993 : 15) and by implication for this discussion, the opportunity to participate in debate as 'knowers'. This was also a feature in the study with health visitors who revealed tension between their personal experiences and public or self expectations in discussing their knowledge and learning sources. There was insistence by a number of health visitors that it was not necessary for every health visitor to have the same life experiences as has been demonstrated in a number of examples from the data.

The argument presented in this chapter has shown health visitors struggling to place their professional and personal experiences within the scientific framework which formed their education and training and which governs the basis of their work. In the study there were many references to experience being a normal contributor to knowledge, so that it appeared as an assumption that underpinned their practice. What was less clear was how this informed practice, even though experience was

seen as a universal teacher albeit it in conjunction with more formal ways of learning as the following extracts indicate.

Yes, I think your life history does have a knock on effect. I think it's very hard to not let that affect the way you see the problem... you sort of gain experience by going along these different routes. (Sonia)

I do believe experience is very important... but you have to keep up to date as well... therefore I would have said, that is, I believe that er studying and going on - or knowing - or doing some research, is still, is equally important as experience. (Shirley)

What springs to mind is a kind of gut feeling erm which I feel comes with years of experience. Erm as a newly qualified practitioner I certainly don't remember having gut feelings about things and in recent years I can think of... I just had this gut feeling (Cynthia)

In addition the following comment shows the sensitivity of acknowledging that personal experience is a resource in health visiting and a source of knowledge and yet it is seen within the context of conventional science, measurement and the need to be seen doing the job according to 'professional' standards. However, it is also argued here that it reveals a transition in outlook, but it is not fully valued by the participant. Christine acknowledges the tension in her comment which reveals a change based on her professional and personal experiences.

...when I first went out... maybe I used more scientific knowledge then... 'the Department of Health said this, or this.' I don't feel that I need so much back up, you know. Occasionally I will say 'Government guidelines say this' but just if I need that bit of back up. (Christine)

Later in the interview she returned to this theme, linking her way of working with personal experience of child rearing as well as the professional development.

I suppose I have become more confident, and with that you acknowledge to the parents that this may work, or it may not work, there is a certain amount of trial and error in child rearing... I'm not so regimented as I would have been - and because I am not worried and saying 'look your baby hasn't put on five ounces this week' - I hope that is helpful to the parent. I am quite flexible... the knowledge I have comes from every source, personal experience, reading, contacts with other professionals, contacts with clients, contacts with GP's. (Christine)

It is quite clear that the health visitors in the study utilised experience and knowledge to support their work; what is of particular interest is how they incorporated their own life experiences as a resource.

Conclusion

The arguments discussed above have shown that there are different views on how feminism views experience; and in a number of ways the data has illustrated this in practice both from individual health visitor's personal perceptions as well as their application to the work. The concluding chapter will examine the potential of the curriculum to provide more positive effects for women's health if there was overt application of feminist epistemology to illuminate and transform health care practice. Issues to do with health care practice and the monitoring role of the employer is examined in the next chapter. The argument for a feminist interpretation of their work with women, is carried through to consider values and surveillance within the National Health Service.

CHAPTER SEVEN

EXPLORING THE CONCEPT OF SURVEILLANCE

... health education and also reducing the risk of cot death, which you know I must present as a government leaflet and I say “I must give it to you and I have to work through the leaflet with you, because I have to record that I have discussed this with you”. So I make that quite formal. (Deidre)

Introduction

This chapter gives an insight into the work of health visiting and the debate about its nature resting between the visible quantification of contacts and content and the hidden process of care and the on-going relationship which is important for family support and health promotion.

Having a basis in policy has been an evident thread through the history of health visiting (Dingwall et al 1988; Symmonds 1991; Hart 1994) and yet this has not prevented a rather individualistic and artisan approach to the work - such that the nature and extent of the work has been labelled as invisible (Littlewood 2000:598; De la Cuesta 1992:193). In many ways it has been a very private job, with little management control and the argument introduced in this chapter shows the effect of increased surveillance by employers. Carnell et al (1999) reporting on a simulation exercise which was facilitated by the Office for Public Management, used a policy approach to the health visiting function, namely the necessity of working from policy documents as a means of establishing the core functions of health visiting.

At the time of data collection, the NHS Reforms which commenced in 1989 had gathered momentum and there was an emphasis on public accountability which had not previously been seen. The health visitors in the study were struggling to accommodate this new dimension to their work in which they were required to code all activities and the content or topics covered with clients in a format for adding to a specified national data base. Thus the thesis provides a glimpse into a particular time frame and insight into a set of circumstances in the life of the health visiting service which cannot be repeated. Also, in fulfilment of the aim to uncover and make transparent some of the more invisible aspects of health visiting the imposition of a new coding system into health visiting could have been seen as a major contribution to this. However the data revealed that this quantification was questioned and resisted as a useful mechanism for adding value to the understanding of health visiting. It appeared to work against care and experience as paradigms for the deeper level of health visiting work.

In order to analyse the data a unifying framework of surveillance has been used. This is applied to the data in a similar way to that of invisibility. It is seen both as an abstract concept, introduced through the writings of Foucault, which raises issues of the gaze, power and resistance; it is also seen as a reality in the world of health visiting where surveillance is a required aspect of the work. In addition, and interestingly, the health visitor is subject to surveillance through the new contracting and data collecting system and is herself a surveiller of clients. A second analytical

tool is the juxtaposition of ‘surveiller and friend’ which has been seen throughout the history of health visiting.

Issues explored relate to this paradoxical situation of ‘surveilled and surveiller’ and the analysis shows how surveillance as a process may reinforce gender blind work, which has already been seen as a theme through the data. A second theme recurs and this is legitimacy of the health visitor with clients as being enhanced by the personal experience of being a mother. Deconstruction of the health visitor-client relationship reveals a potential for a changed outlook and ideological dissent from the dominant culture and context of health visiting; this too builds upon previous analysis which examined transformation and transition within health visiting practice.

The chapter is in two major parts, the first examines the health visitors within the NHS being subjected to increasing surveillance; the second part concentrates upon the surveillance aspects of the health visitor-client relationship. The first part sets an historical context for gendered thinking in health visiting and asserts its long term effect on the invisibility of the work; against this, the possibility for transparency through the new recording mechanism is considered. The concept of surveillance as a tool for control, through the writings of Foucault is introduced and ways in which this can be utilised through uncertainty is identified in the data. Resistance and questioning are seen as outcomes from the imposition of increased surveillance. Questions about gender stereotyping and role behaviour are raised here. The second

part utilises the concept of surveillance to examine the work of the health visitor with clients and draws upon previous work to illustrate some of the unsatisfactory aspects in health visiting. A conclusion is developed that shows surveillance as a contributor to gender neutral work. The chapter finishes with an examination of how deconstruction of the health visitor-client relationship reveals a further way in which the health visitor forfeits her position as a woman. But to counteract this shows how a reduction in the binary system of relating could provide momentum for a collective ideological challenge to the dominant positioning of health visiting.

1 THE SURVEILLED

1.1 Health visitors and the work situation

Both historically and for modern times, Davies C. makes the point that the invisibility of health visiting is linked with gender issues and with the role relationship that is both 'surveiller' and 'friend' (Davies C. 1995; 1988). From the links with the Sanitary Movement and the conceptualisation of the work by men in that movement and later by the Medical Officers of Health there has continued to be lack of clarity about the work. They stand accused by Davies as having been limited in their outlook 'They had a gendered and hence a truncated understanding of the field' (Davies C. 1997: 111). This has continued to influence health visiting into the 21st Century where there is still lack of clarity about the core mission. In the history of the Health Visitor Association it was noted that there was a consistent difficulty about the nature of health visiting, during the hundred years that were being

celebrated, ‘... members were often vague about their core mission’ (Smith J.1996:51). From the analysis in this thesis, it is suggested that a single core mission has not been a function of health visiting and that this is linked to the gendered dimension of the work. Women have been in a ‘professional’ gender neutral relationship to other women. It is further suggested that a crucial tension inhibiting the core work has been the pull between the function of the gender neutral surveiller and that of ‘female friend’ in a reciprocal connected relationship. This chapter continues the exploration of women health visitors, this time examining the impact of surveillance upon them and the way that the more measurable work supports the gender neutral activity and this theme which has developed through the thesis.

One of the difficulties faced both in nursing and in health visiting, from a feminist analysis, is that of providing insight and credibility for the view that organisational mechanisms, for example, the surveillance of the quantification of their work, are based in a gendered model which has ignored the care giving aspect (Davies C. 1995:145). Health visiting and nursing appear not to have embraced a curriculum and language which recognised the gendered world within which they are employed. In the research almost no-one spoke of ‘woman’ or ‘women’; the most frequent term of reference was ‘people’. This was apparent even in the crucial field of the womanly work in breast feeding

I think it feels different being able to say to people what your experience is. I think one of the major things is breast feeding. I think you can help people with breast feeding, preparation with breast feeding and going through the breast feeding process. (Margaret)

The neutral service, not reliant upon real-life women is demonstrated here. It suggests that women, or perhaps people, shouldn't be visible in health visiting! The comment on breast feeding, by Margaret, shows a very interesting example of gender blindness and supports earlier examples of gender blind commentary. An illustration of gendered thinking in the academic world reminds that health visiting and the National Health Service are not alone in being socialised into an hegemonic way of thinking (Connell 1987). When Coate (1999) was reporting on the development of women's studies in higher education, she described an unaware gender blind comment as 'an interesting slippage'. One of her participant's spoke of a woman head of department being seen as a female rather than an academic, by implication that the term academic usually referred to a man and thus rendered the term 'academic' as gendered - an evidence of the binary system of thought (1999:146).

Within feminist literature there are many insights in respect of invisibility, subordination and survival which give some ideas about women's survival strategies and hence a possible survival strategy of health visiting.

...and making us deny our visibility as the other in order to embrace invisibility and silence as a strategy of survival. (Lewis 1993:9)

It does appear as though in practice and curriculum development health visitors have maintained a quiet but determined advance in their own survival, which has always striven to be 'one step ahead'. Currently that is seen in debates to raise health visitor

education to Master's level. Another kind of strategy is also suggested, which is that undisclosed or unrecognised core work is that of care for clients and that the quality of tenacity has been seen here; thus linking survival with connection and relational theory. However, it is also acknowledged that survival has required state intervention and support.

There have been a number of allusions to survival and demise in health visiting, including that by Batley (1983:97) from her privileged position as Director of Council from 1975. In her history of the Council for the Education and Training of Health Visitors, during the preparation for the 1979 Act for the Education and Training of Nurses, Midwives and Health Visitors, Batley identified the possibility that there would be no understanding nor support for the health visitor role at the strategic level of professional development and regulation. Nevertheless, health visiting did survive this troubled period, health visitors' nationally were engaged in lobbying for the title of 'health visitor' to remain in the Act and the principles of health visiting were subsequently incorporated into the foundations of the new Project 2000 nurse education.

1.2 The transparency of accountability

During the second half of the 1990s the pressure on 'value for money', transparency and accountability for evidence-based practice in the NHS gathered momentum with the need for managers to have systems in place to make explicit the work

undertaken. Both the NHS Reforms and the new NHS Modern and Dependable (DoH 1989; DoH 1997) support the need for this move towards a quantitative, best evidence approach to care. It can be seen from the health visitor interviews that managers had introduced new recording systems and an anticipation that health visitors would co-operate with the new ways of surveillance of their work practices.

The organisational surveillance was related to the policy documents which arose from the NHS Reforms and required the employing authorities to become systematic in their approach to recording health visitor activity. This was supported by changes in technology and the introduction of computer assisted data bases. Two types of measurement have appeared important - those for measuring the work efficiency of the health visitor and those for measuring the kind of work being undertaken. All participants spoke of the computer based system of recording for various statistical returns required by the employer:- numbers of contacts, types of contact and types of outcome were the main feature of the comments by health visitors. Heather summed up one of the dilemmas threaded through the comments, while Sonia reflected another theme which was to do with the contracted element of health visiting.

... they're looking at controlling, seeing what we're doing. And I'm not saying that's wrong. I think you should be more accountable. You should be able to say what you're doing, how you're doing it and why you are going there to do it as opposed to doing it here [the health centre]. And I think there is definitely more looking at why you're doing it and what you are doing and what is the benefit going to be and for whom. I think there is a change. Whether that can be seen as questioning professionalism. I don't actually see it like that, but some people feel threatened and feel it's just questioning their professionalism. I don't. I think it's just a case of evolution and the process which goes on. (Heather)

Certainly, you know, managers are looking at where our time is being spent. You know we have the FIP system which is a computer system... contract agreements are made for contact purposes. As well they are looking at the type of work we are actually doing out there. (Sonia)

Although there is an emphasis through the data that the surveillance on their number of contacts was linked to the GP fundholding and purchase of services, others did acknowledge that the audit process was across all health visitors.

We have all been told what we did last year, and it is even non-fundholders. From the point of recording, I suppose we are more aware of accountability, of what we must achieve now than we were... Very much more accountable. (Christine)

Well, in the capacity of care that we use, erm, when we register our contacts, we'd actually put down the mother's computer number. And then right next to that you'd have appropriate codes that meant you were looking at the woman's health. Whether it's about the woman's diet, that kind of thing, post-natal or ante-natal, domestic violence, drug and alcohol abuse. All of these things we can actually identify. (Wendy)

However, for some health visitors there was a misunderstanding or lack of clarity about the potential of the data base, both for the management of the topics being coded and for feedback or retrieval aspects. A question raised here and with later evidence from the data, is how the health visitors could have seemed so ineffectual in making representation to their employers about these issues.

... but apparently on the FIP system it picks the first one only, so you have to decide which one is more important [activity / topic carried out]... I mean I get absolutely no feedback whatsoever from these people who collect this data, and use it for whatever reason. (Lindsay)

... the codes are going to be refined further, we shouldn't code the weight first because anyone can weigh a baby, that isn't the most significant thing we have done. It is the primary purpose we should be recording. So we sort of - what was the primary purpose of that contact; we have to be thinking along those lines. (Christine)

At this point it can be seen that there were problems in the way the systems were working and that the participants were far from convinced about the efficacy of the new systems. The effectiveness of information systems within health visiting and community nursing was challenged and considered an unsuitable mechanism for identifying the knowledge base and activities undertaken by community staff (Cowley 1993). The outcomes of introducing new surveillance techniques is explored in the next section.

2 AS SURVEILLED SUBJECTS : internalising the gaze

2.1 Panopticon surveillance : the gaze, resistance and struggle

Simply introducing new systems does not automatically bring about co-operation and change, although the inner recognition of on-going surveillance can assist in the process of developing new norms. One framework for explaining a link between surveillance and self-monitoring is that identified and applied by Foucault to disciplinary technology through the principles of the Panopticon Gaze (Prado 1995; Ribbens 1998). This relationship is described, by Prado, as needing involvement by the individual to the point of inculcating new values.

...if the subject can be made complicitous in the surveillance through adoption of certain additional beliefs, that is through the internalisation of norms, then control may approach near-perfect completeness and efficiency.
(Prado 1995 : 61)

The research showed health visitors in an uneasy relationship with the new processes of supervisory surveillance. Many believed this contrasted with and curtailed their previous autonomy, when they were trusted to do the work without the current emphasis on recording all activity. The extracts from Carolyn and Julie are typical of this view.

I know it's important and we do have to have a way of measuring what we do... but having to actually record all the different kinds of advice that we might give - have given - that one contact and the amount of time we spent there and how many miles. I think, 'why can't you trust us to be autonomous and erm, do what we feel is right without having to record all these tiny, nitty gritty bits, bits and pieces.' And I think that's changed with health visiting. We were much more autonomous. (Carolyn)

... and I think health visitors were very much left to their own resources before, and trusted that they were doing what they were meant to be doing, or what people wanted us to be doing... The ironic thing though, is that at the end of the day we are not doing anything differently... you are not actually spending more time on client contacts, you are just dividing it between more people [the items recorded from the visit]. So I think that's the thing we can't get to grips with. (Julie)

Neither Carolyn nor Julie, nor other health visitors interviewed, gave any hint that the changes in the process of more transparent working practices could ultimately be of value in providing a more explicit picture of the work, although Carolyn did acknowledge that it must have importance. Implicit in her comment was that the new

recording system was a measurement device for the authorities to monitor the work output by health visitors. The success of the panopticon technology of discipline is seen in its work on the inner self to produce conformity. This is in an abstract fashion and does not require the 'architectural functioning' of a physical Panopticon (Dreyfus and Rabinow 1982:190), but is the individual becoming their own guardian through self-regulation and self-monitoring. However the tension in this is that the individual may produce resistance to the system and does not develop the compliance desired by the organisation.

Some of the resistance is seen within the next comment by Carolyn, who is in the paradoxical situation of both resisting and complying. By contrast Shirley shows a self-monitoring dimension, within a context of the unseen but 'seeing eye' that is at the heart of the panopticon style of surveillance. However, she also gives the sense of a 'bottomless' pit in the external surveillance, which also contrasted with her previous sense of expertise in self monitoring and internal regulation.

One thing we've had to do today, which I feel quite negative about really, is collating data for what we do every day and each contact, face-to-face contact. We have to record absolutely everything. And - and I know there's a good reason for it, but it seems to take time out when we could be doing the work of health visiting... three quarters of an hour... I know it's important and we have to have ways of measuring what we do. (Carolyn)

I think it's for you to achieve really. That's how I see it. I mean I try to always achieve and maintain high standards. I'm quite hard on myself. But erm - no I don't think anyone ever - but they would know how much you do because we have diary sheets. So there is auditing of the contacts you have and the time you spend and what those actual contacts were because we code contacts, so I mean there is - there is somebody somewhere knows what you are actually doing. But nobody ever comes back. (Shirley)

The health visitors in the study were generally co-operative with the new recording systems although were cautious about them. From an outside point of view it appeared, to me, that they were in a transitional stage in the internalisation process which accompanies such a change. So that although in Prado's terms they were complicitous in the surveillance process, they had not yet adopted the necessity of the record keeping system of surveillance, as a value or belief system.

As well as demonstrating the tension and some frustration with the data base, these comments illustrate the needs of the employing authorities to seek out information as they experience power from government being exercised upon them. Domination appears as a process which cascades 'down the line', so that power and domination are not vested in one place (Dreyfus and Rabinow 1982 :186), and there is always 'power being exercised on the dominant as well as on the dominated'. Of interest here, is that health visitors as well as being 'dominated' by their employers are themselves in a dominant position with clients and this relationship will be analysed in the second part of the chapter.

Within this uneasy relationship there were signs of tension or struggle about compliance to the new surveillance techniques for quantification. For example in the context of family support.

I feel I probably do give them more time than my manager would like me to do. If I do feel that a client needs a two hour session, then I would give a two hour session. I would not arrange a half hour visit and then say their 'times up' and I'll come back next week. I strongly feel the client needs the time and the attention at the time they need it, and if I don't give it them the whole relationship will break down. (Joyce)

This leads back to the questions about the nature of health visiting and the tension between surveillance and a satisfactory model for the work with women which incorporates the central beliefs by health visitors about the health visiting relationship.

3 POWER OF THE GAZE

3.1 Maintained through ambiguity and uncertainty

Unresolved questions at this point link with the 'unconfident nurse' concept (Strong and Robinson 1990). The study data on the unconfident nurse has resonance with the study participants, who were managed by mainly women managers, and consistently through the data reported lack of vital information being passed to them, for example the target number of contacts which had been commissioned. I have viewed this as unconfident female behaviour which I do not believe would have occurred with a male work force placed in the same position. A further question, linked with the question about the lack of information on the way the data base worked, was 'how was it that health visitors did not know the target numbers?' Was this a demonstration of power by managers in respect of the stereotyping of a female workforce who were in the dominated position? Where was their voice?

Were they seen in the binary position of female nurse against the general practitioner stereotype of a male - to be in the dependent role and not to be over concerned. An example of this from the data is from Cynthia, a very experienced health visitor, who worked in a General Practitioner Fundholder practice

The target is generally not divulged to the field staff, I find, which is difficult. Because it's the managers who go in and discuss with the GPs what sort of contract figures they want. The GP surgery gets a monthly sheet of what should have been for the month and what has been achieved. And the managers have said that we shouldn't get those because it winds us up too much. We get too twitchy if we haven't achieved the target. (Cynthia)

One of the problems in respect of contracting for numbers was that some health visitors did not know how many contacts they were required to make, nor the basis upon which that agreement had been reached. It appeared that some contract agreements were made in relation to the number of contacts achieved in the previous year. All participants appeared aware that targets had been set and that this was a significant change in health visiting practice - that they were being monitored against the targets and would be called to account if there was a discrepancy in respect of expected or contracted numbers. The fact that some did not know what the contracted numbers were, yet were being scrutinised, added an element of uncertainty which would tend, in 'panopticon' terms, to produce a very careful accounting and recording system as the following extracts reveal.

There's more emphasis on counting numbers, that's definitely so. It's quantity not quality. I'm attached to a GP Fundholder and they've contracted for a certain amount and certainly every quarter we're sent out information about targets and whether they're under or over achieving those targets. And we're encouraged to meet those targets, plus or minus 10%. If we do less than that, or more than that, we have to justify why that has happened. (Maureen)

They [the GPs] seem as if they allow me to - well to do my own thing. Having said that, they have set activity levels of 23 visits a week, which isn't unreasonable. It does allow you what I feel to be quality visiting... my surgery gives me enough time... I try to qualify what I'm doing with that time... after all, the GPs are paying for your service. They're entitled to know. (Deidre)

It's only just come to light, how they were actually measuring, how they were going to allocate the budget really - so we were kept in the dark on how our work was being monitored and measured. (Greta)

Clearly there has been a change in the way in which employers need to account for the work of their staff and this has translated into different kinds of responses from health visitors. However it is argued here that this is an evidence of a deterministic practice towards valuing work that relies heavily upon processes that are not readily subject to quantification. It is also suggested here that hidden targets contributed to the culture of invisibility that has been central to discussion in the thesis.

Surveillance has become 'a way of life' for many, not only in the health services as discussed here, but in education (Coate 1999; Skeggs 1995), as a feature of modern life (Ribbens 1998), and in social work (Humphries 1997). In discussing changes within health visiting there was consensus across the health visitors that new ways of

recording and coding the work had been introduced and that it was difficult to adjust to the changes and prevailing attitudes that tighter systems had produced. In 1994 the Audit Commission report 'Seen But Not Heard' made very clear statements about the lack of complete and accurate records of work undertaken, including the fact that half the health visitors interviewed for the audit, (n = 30), had offered extra health surveillance assessments to children without the commissioner being aware that extra work was happening (Audit Commission 1994 para 79, 80). This provides some external evidence that surveillance through recording and audit can make more visible the work that is undertaken by health visitors against agreed targets. The struggle and dilemma for health visitors is that they believe that this does not represent the expertise of their work at a deeper and hidden level.

It was also apparent through the Audit report that effectiveness of health visiting surveillance was measured through the number of referrals (para 82-84). A view was also expressed that some clinic sessions had ill-defined roles in respect of family support and surveillance. The sub text appeared to be that work which was definable was highly valued, and while family support and health promotion were also recognised as part of the specialist child care function (para 86,87), these should be within the context of an audited service. This points to an inherent tension within the health visitors' work, which is the visible and measurable surveillance work and the less measurable, often hidden and invisible work, of 'support' and health promotion. In discussing measurement and standards some of the health visitors were quite clear

about the relationship of referral to outcome measures. Also the inherent dilemma when health visiting is viewed by managers as an 'end point' contact, instead of an ongoing relationship or service, which is the less measurable, more invisible, aspect of health visiting.

The outcomes are the referral system, The outcome is - a family have sorted out their problem - and feeling that - you know that - that actual contact will stop then, that you've sorted the problem.. I think it's based on a more medical model more than the models we're used to, which are more social... you know 'that any fears can be cured and there's an end to it! But experience tells us that, you know, these issues that you're dealing with, like for instance a violent partner or financial problems, often don't get cured. You know those sort of issues are hard to code in anything ... and there often isn't a definite end to it. (Sonia)

This shows the complexity of the issue, a recognition for the fact that there can be an 'end point' and a referral and yet there is a recurring nature to many situations which are identified through the contacts based in the child health surveillance system. This was commented upon by Wendy, who had been discussing child health surveillance and 'packages of care' which are difficult to quantify when there are family difficulties, and that standardised 'tick boxes' don't account for the range of work.

And I think, you know, the type of work that we do, that we can't put it in a little box, really. You can't say, well this will take me three visits and it will all be sorted. I think you need to convey it [the need for extra visiting to the manager], because maybe by doing that kind of work you can put forward as being a reason why you can introduce skill mix into the health visitors workload. (Wendy)

These comments suggest tensions in disentangling and making more evident the levels of emphasis which the job might have. Also the inadequacies of a supervisory surveillance system to 'capture' the essence of the work with its more hidden elements of relationship and incomplete closure in respect of health care 'action'. These tensions also go some way to explaining why it is that health visiting is not easily described at a level sufficiently deep to engage the commitment of health visitors, both individually and collectively, in agreement with a visible and focused core work.

4 THE GAZE RESISTED

4.1 'Quality' and quantity' : How to measure and value the unseen?

There appeared dissonance in several ways in respect of the surveillance technique, for example in time management , quality or quantity in the work, and measurement of outcomes, but there was also a gradual recognition that the new systems of submitting accounts of work done would be a continuing feature through the computerised recording systems. For example the following two extracts are typical.

And they're saying, 'record everything you do'. But you spend so much time recording it - the more work you do, the more paper work you get and it's just ridiculous really. Have you seen our activity codes? This is a real chore. (Lindsay)

We are under pressure to complete diary sheets and to return them regularly on time, so that they can monitor the activity. (Joyce)

Although monitoring activity had always been a necessary part of health visiting and seen as normal good practice, the regularity and strength of the comments from the participants made it clear that there was a significant shift in the current requirement from the employers. This was a point of tension in respect of self-monitoring for quality in the work and responsiveness to client needs. Rosemary acknowledged understanding of the employer needs, but would put her assessment of client need before management consideration. Earlier in this chapter, a similar view was expressed by Joyce in support of the struggle with compliance to the new systems, this was also seen in the chapter which showed the care and caring aspects of health visiting.

... they've asked for a home visit, they've given a minor reason - I wouldn't cut them off - if somebody asked me, I would go. I know that may not tally with economics and all the rest of it, but that's because of my experience. I've always found that - nearly always - found that there's something else.
(Rosemary)

Other health visitors were concerned about quality and how this had been affected by the emphasis on achieving specific numbers of contacts. Deidre felt she had sufficient time, but Maureen and Julie, like Lindsay were questioning this. From these comments the assumption is that the 'quality' aspect is related to time spent with clients and with the opportunity to relate in less tangible ways than would be quantified through the computerised systems.

... they have set activity levels of 23 visits a week, which isn't unreasonable. It does allow you what I call quality visiting. (Deidre)

... people aren't concerned about the quality of the contact. (Julie)

... the quality has gone out, you have got to do so many visits a day. (Lindsay)

There's more emphasis on counting numbers, that's definitely so. It's quantity not quality. (Maureen)

In contrast, there was some evidence that employers supported the less visible part of health visiting, which could be seen both as an 'activity' known to have some preventive care basis but also support in a caring fashion for those perceived to have an identifiable need. This was in relation to elderly visiting and to bereavement visiting

We've gone back to widening our role and our brief with age groups. We're encouraged to be more generic again.. taking on different roles with older people for example. We're given that work by the doctors and we are encouraged by our managers to do that work if they request it... and also I think we are encouraged to do bereavement visits now. (Maureen)

The tensions seen within this chapter show a drive to increased visibility through monitoring and surveillance of the obvious activity and inputs. What is not clear is how the process of 'quality' takes place, which it is arguable is an input rather than an output.

5 HEALTH VISITORS : AS SURVEILLERS

5.1 Surveillance and resistance in health visiting : client to health visitor

Resistance to surveillance is regularly discussed (McNay 1992; May 1992; Porter 1996) and has been identified in respect of the health visitors in this research. A study that examined client behaviour in relation to the perceived surveillance activity of health visiting and surveillance in therapeutic communities will be used as a case study to illuminate the data on client relations (Bloor and McIntosh 1990). This retrospective study, which drew on their own individual previously reported research data, aimed to analyse resistance through relationships in which power was a feature. Surveillance in the clinical gaze was taken as the power relationship within the therapeutic encounter, based upon the work of Foucault. Bloor and McIntosh comment ‘... parenthetically ... we have not missed the irony that our own research methods entailed the surveillance of our research subjects’ (1990:162). They were engaged in more than one level of relationship with their research subjects, which is a not dissimilar tension in the surveillance behaviour of health visitors.

In this study, health visiting surveillance has been seen through the conduct of health visitor’s work with families and young children, through the contractual commissioning and auditing part of the work, through the available technological advances to code and quantify work undertaken through data bases and from ideological changes in what constitutes quality of work through relationships. It was also defined as a procedure to ‘oversee and monitor’ in an unsolicited process as well

as providing an ‘opportunity to discuss broader health issues and concerns’ (Audit Commission 1994:83). Health visitors are both undertaking varieties of surveillance with clients and are themselves under surveillance through their recording and referral systems. Thus surveillance has different settings and also different forms. Three types of surveillance were identified - covert or naturalistic surveillance and supervisory surveillance which were most applicable to the therapeutic community; thirdly, surveillance by proxy or self report, which Bloor and McIntosh (1990) considered to be a modern technique of surveillance when contrasted with the Panopticon. Although in agreement that health visitors do rely on self report surveillance by carer’s in the work of monitoring child health and child care, with usually the mother as the expert (Hall 1996), it appears that the Panopticon technique remains a suitable analogy for the unseen gaze exerted upon health visitor’s own work, the category of supervisory surveillance by the employer.

In the analysis from the original data, McIntosh (1986) had noted the main aims of health visiting, from a consumer perspective, had been social control which included ‘policing of child abuse and neglect, the monitoring of maternal competence, the provision of support for the inexperienced or inadequate, and the assessment of the home environment.’ (Bloor and McIntosh 1990:169). A more recent analysis of health visiting has seen it as social regulation (Peckover 1998). This current study acknowledges these inevitable conclusions through the perceived role of the state in the maintenance of the health visiting service, but has been making an argument that

this leads to dissonance in health visiting as collectively health visitors pull towards the 'friend' dimension of care and connection through their shared experiences.

This intentional behaviour (Heron 1990) contrasts markedly with the resistance to health visitors seen in the case study, where individual ideological dissent, in the form of covert resistance by clients, without personal confrontation was identified by Bloor and McIntosh (1990). The issue highlighted was the lack of legitimacy in health visiting discourse, in particular mothering and infant care in which they, the clients and other experienced lay advisors, were seen as more valuable. This was confirmed in a recent survey in which mothers rated their partners and own mothers, as the preferred source of advice, with health visitors coming third, fourth or fifth (Bowns et al 2000). The original data from McIntosh strongly emphasised that health visitors should be mothers and that competence was related to personal experience. This issue was seen as a dilemma in the current study, within health visitors' own perceptions about their work and life experience. As such it resonates as a very important theme for both practitioners and their clients. As has been noted previously there were many comments about the necessity or otherwise of being a mother to legitimise the role. A further example from the data shows some of the duality about personal experience of child rearing and a recognition that this is about credibility.

... who has had a similar experience and a person who hasn't, whether we would be equally perceptive in our work. I suspect that we probably would be, because we all know that you don't have to have children to do health visiting. But yes, I think they can identify with you more... I suppose it gives you some sort of authenticity, they feel that you know because you've been there... I mean I had children in the first place, so... but I have changed. [following a series of complications with a birth and new infant after a long interval from her other children] (Lindsay)

There is reflexivity about this dilemma, which was seen elsewhere in the data, but it seemed to remain as a 'given' rather than being viewed as a subject to be deconstructed or reconsidered.

The example of covert, non-co-operation given in the Bloor and McIntosh study was of non-compliance by the clients with the principles of weaning and the maintenance of a milk diet for infants for the first four months of life. There is a long history of women managing their child rearing in ways which are resistant to perceived beliefs of health visitors, a notable study was in the 1960s when Newson and Newson (1965) employed lay workers to survey child rearing practices and discovered practices such as dummy sucking which would not have been revealed to health visitors. Escape or avoidance, was another common resistance by clients, in that they simply did not attend the child health clinic or did not answer the door. These resistances and health visitor's views have also been well documented (Graham and McKee 1979; Sefi 1988; Mayall 1993). Concealment appears linked to activity in which health visitors might criticise mothers, as in the management of weaning or in inaccurate accounts of the child care being given. A further area of resistance has

been in respect of advice giving and expectations (Heritage and Sefi 1992; Kendall 1991; Robinson 1987). Thus a number of issues in respect of practice and the need for change have been highlighted in this discussion.

An assertion was made in the Bloor and McIntosh study, that resistance to health visiting surveillance had an enduring quality because counteraction is hard - there is no right of access to the covert activities of the client, the activity of concealment may not be clear, and 'politeness' may constrain the health visitor from attempting a counteraction. Politeness as a concept, based in 'the conventions of medical gentility' is rather tenuous and does not accord with the current data which has shown health visitors development in challenging and confrontational skills. Nor does it take account of the changes in curriculum to develop an understanding of assertion and negotiation skills and activities. Health visitors in the study were invited to comment upon their own development and some were able to identify skills of assertion and reflection upon these changes. Thus the nature of politeness and counteraction may not be so apparent in the fifteen years since that study was completed. An example of change comes from Grace.

And I'm not hesitant - I'm not afraid to say 'are you depressed?' Whereas some years ago I wouldn't have been able to say that... and even talking to people who are grieving... before, I think I would have let things slip, really, and not mention - if they didn't mention it, I wouldn't mention it... And I wasn't afraid to confront them, which I wouldn't have done a few years ago. And now he won't smoke in the house and he won't allow anybody else to smoke in the house. (Grace)

Thus surveillance has been seen as operating on several different levels, including in health visiting the sequence of both conducting surveillance and being the subject of surveillance. The issue of resistance has been introduced as an inevitable sequence of control, and yet control itself, may have positive outcomes in for example the greater visibility of health visiting activity. The uneasy relationship between the health visitor and the client has been discussed here, which in a number of ways contrasts with the perceptions of care which were explored in a previous chapter. However there are links with the analysis provided by May (1992) in which he demonstrated how an increase in holistic care could be viewed as surveillance of all personal exchanges with a patient when analysed through the operation of pastoral power as described by Foucault. By contrast Porter (1996) when using Foucault's framework to examine power showed that individuals do have the capacity to resist surveillance and keep their personal lives 'private' against caring but authoritarian questioning in nurse-patient relationships. An argument being developed through the thesis suggests that there is a need to change the base of knowledge and power in the relationship of women with women as seen in this example from health visiting. The next section shows the context of routine child health surveillance in health visiting and its relationship with preventive health work, the paradigm shift in health care towards health promotion and positive outcomes of power. Deconstruction of surveillance in the client - health visitor relationship brings this chapter to a close.

5.2 Gender disappears in the work of surveillance: a taken-for-granted activity

Surveillance work, which is commissioned, is seen mainly in the immunisation programme for all infants and children and the monitoring of child development, both offered within specified programmes provided by the Department of Health and with full recognition of the inherent difficulties (Butler 1989) and the recommendations of the Hall Report (Hall 1991). The Audit Commission (para 146) urged a full specification of local need and an accounting system which showed the basis for commissions, monitored the service given and showed the relationship between the contracts and the outcomes achieved. Carolyn linked this aspect of surveillance with the contracting process and job security.

But it's - its becoming now that we have to be seen to be doing these things, for example immunisations, to keep our jobs really. So I've no option but to say, 'yes I'll do it'. [this was to physically give the injection as well as recording it]. - if you've given twenty four immunisations in one day, they think 'oh she's doing a very good job here, we'll pay her money, we'll keep her!' (Carolyn)

In this example the emphasis is on a visible and measurable commodity in the work which could be submitted as statistics for the Department of Health. A value of surveillance being a core dimension to health visiting is that it contains ways in which the service can be quantified and it can serve as a basis for both primary prevention and public health work (Armstrong 1993). However, too much emphasis on

targeting from the provider of services is said to lead to some adverse consequences including the reduction of client advocacy (Dingwall and Robinson 1993).

Preventive work is built upon the ability to establish baseline data about what health needs are evident in a family, which is essentially a core activity of surveillance. Health education and health related changes, a positive activity, and monitoring child care and development, a potentially more negative activity, both appear to have an essential root in surveillance as a work process and contribute to the perceived ambiguity in health visiting (Bloor and McIntosh 1990; Littlewood 2000). A paradigm shift from surveillance to health promotion is increasingly evident in health care and is seen as a way of moving power from the surveiller to the recipient (Hall 1996; Armstrong 1993). Surveillance appears as a key factor in the gap between the activity of care and the dilemmas around the scientific and experience related practice which were discussed in the previous two chapters. Surveillance also carries with it the essence of power in the sense attributed to Foucault, which is of a dynamic state 'exercised in social relationships' (Bloor and McIntosh 1990:160) where knowledge and power are interlinked as in the Panopticon example of surveillance and technological control.

For the health visitors in this study, there is power and knowledge operating both with the clients and with the employers which finds its focus in the quantification and coding of the work in all its dimensions. The assertion by Bloor and McIntosh that

‘immanent in the discourse of health visiting are relations of power’ (1990:163) and that power and knowledge are intermingled tends to relay to the reader that this a dubious, perhaps questionable state, albeit inevitable. This does not develop the productive attributes of power and knowledge as indicated by Foucault. For example McNay (1992:3) identifies ‘the potential for agency and self-determination’ as central to Foucault’s ideas ‘that power is a productive and positive force’. This is in the context of technologies of the self - domination and subjectification - in which it is suggested that individuals can be active in the production of their own identities and in respect of their own autonomy. In application here, the argument about utilising one’s own autonomy can be seen in productive outcomes such as measurable health changes and the reduction in morbidity and mortality that are evident through surveillance techniques. As employees and subject to surveillance, productive aspects could be seen as greater self awareness in respect of the work, albeit tinged with a negative view of greater control by managers.

The language of ‘discourse’ upholds the position developed by Foucault which rejected the ‘distinction between science and ideology and, therefore the idea that there are discernible, objective truths’ (McNay 1992:25; Francis 1999). The following comment by Foucault suggests the need for spaces in which to consider the possibility of a variety of ‘truths’ that may be present in any discursive offering, ‘...the problem does not consist in drawing the line between that in a discourse which falls under the category of scientificity or truth, and that which comes under some

other category, but in seeing historically how effects of truth are produced within discourses which in themselves are neither true nor false' (Foucault 1982 :118). The debate in the thesis moves to a deeper analysis of the surveillance issues, to consider the possibility of these being an example of hegemonic control and therefore open to collective or individual ideological challenge.

In the case study about surveillance and resistance Bloor and McIntosh noted a lack of 'collective ideological dissent', described as a highly visible counter culture and a form of resistance. It was not utilised by the respondents in their study, except in one possible example which was not with health visiting clients. This part of the chapter will explore how this could be developed by health visitors through processes of deconstruction leading to opportunities to view alternative positions. In particular this will focus on the potential of a feminist analysis of the power within the health visitor - client relationship. One of the attractive aspects of deconstruction is that it allows the holding of several and various ideas at once, without one necessarily holding 'sway' or 'essential' truth. Davies B (1997b:272) goes further by stating that 'Deconstructive thought thus requires us to take on board contradictory thoughts and to hold them together at the same time.' She also considers that deconstruction is a facility to attend to things which are not normally seen and which can lead to powerful agency through being made more visible. In the context of surveillance, which contains within it legal requirement, a further comment by Davies is apposite

By looking ‘*at* rather than *through* the linguistic surface’ we can begin to explore how it is that we can think we have, and act as if we have, (and can be required by law to have) a sense of agency, and recognise at the same time that it is in the constitutive force of discourse that agency lies. (Davies B. 1997b : 272)

Some criticism of deconstruction and poststructuralist argument has been that it reduces, for the feminist, the momentum of the emancipatory project because of the lack of any evident truth - if all discourses are held together (Francis 1999). However, Davies refutes this position by maintaining a working view of agency that incorporates the power of language through reflexive awareness and can produce change.

There is a subtext to her debate, which is in reply to a dilemma posed by Jones (1997), in respect of the perceived purity and correctness of managing post structuralist concepts and positions. A position held through this thesis has been that tools are precise instruments but the way in which they are employed may be various and not always according to the originator’s plan. Thus I have difficulty in wanting a ‘correct’ rendering of deconstructionist debate, as questioned by Jones, but am working towards its relevance and application in health visiting and find the discussion by Davies helpful in this regard.

Applications of deconstruction to the possibility of producing change are discussed in respect of personal legitimacy in crossing boundaries from the dominant culture and

bringing into operation new behaviours. For example - 'speak into existence' - as a way of showing agency in action with other activities of deconstruction, the first being an 'imaginative construction of worlds other than the ones we already inhabit' and the second being 'the deconstructive work we might do to undo the bonds of already existing, discursively constructed worlds.' (Davies B. 1997a : 12,13). Post-structural analysis as a means of recognising and making visible the mechanisms which have led to the situation under review follows logically from this argument.

Davies' argument is applied to gender development and of particular interest to this chapter is the way she analyses the outcome of deconstruction as making visible the binary of the people in the '*ascendant categories*' being dependent upon the '*subordinate category*' (Davies B. 1997a : 13, italics in original) for 'their own privileged, unmarked location'. Within the research with health visitors the issue is to do with both/and development of awareness in respect to binary positions. Whilst it is not unduly difficult to view themselves as in the subordinate category in respect of being the subject of surveillance, the suggestion here, is that it is difficult for health visitors to see and acknowledge a binary behaviour in respect of clients. Thus, although both are women, it is as though in the practitioner-client relationship, there is not an equal relationship but is a binaried pairing that invokes a power relationship. The following is an example of this unaware position using the theme of whether or not it is desirable to have children.

... I mean they certainly want to know that you've had children and have had that experience, although I don't think it's necessary and I say to them because... they certainly have a perception that people should have children.
(Sylvia)

Sylvia had more than one child and was an experienced mother of school age children but appears unwilling, like many of the other health visitors in the study, to relate to the clients as a woman, positioned as a mother and in an equal relationship at that point. There appears to be an unwillingness to enter into the reality of the clients, in the way that Ribbens (1989) heard from the participants in her research when they wanted to 'position' her in this way as part of the research and interviewing process. The suggestion here is that the binary is the professional - client separation, with the professional being in the hegemonic position, which has been taken up by the female health visitor. The client then is in the subordinate position and cannot be equal to the health visitor who has in this way forfeited her experiences as a woman. 'She' could be a man undertaking the work.

By contrast, an example from a health visitor who had experienced a life threatening illness and who, in an unplanned coincidence undertook visits following hospital discharges as well as normal child health visits, described a more authentic and equal exchange which appears to have dispensed with the binary of professional - client

... I had a real flashback - legs shaky - panting for breath - that was an awful shock, that I reacted like that. To some of them [clients] I said 'well I do know how terribly frightening it is because you know, a similar sort of life threatening situation happened to me'... I think it's the assurance that I've come out of it. (Deidre)

There is a hint that the interchange of experiences is downgraded, in favour of the survival outcome, which in turn suggests some dilemma with the personal exchange of experience, which would be consistent with the binaried health visitor position. This is also evident in another example, when Julie, the health visitor both provides herself as a role model for infertility treatment and herself receives encouragement from the client who had experienced successful infertility treatment. This spontaneous disclosure is then censored with excuse, self doubt and the practitioner role of distance from womanly experience.

And I laughed and said 'oh, you know, I'm having treatment as well.' I think it's quite encouraging I suppose for me to see people like her. But I wouldn't, I mean I don't know why I said it that day. I wouldn't normally say anything to clients. (Julie)

One further example shows a participant in a more equal relationship in which mutual sharing occurred after bereavement.

... I remember talking to someone very soon after my bereavement... then getting in the car and bursting into tears... empathy with what she was saying rather than me providing the empathy... she rang me and said 'can you come and see me?' And we did talk on two or three occasions at her request... it certainly moved us both. (Gail)

Again, in the more mutual sharing, there was nevertheless, a sense that Gail was not quite relaxed that there was a reciprocal benefit and that initially her view was that she, as practitioner should have been better able to provide the support. Gail used the word 'empathy' very freely, as did many other health visitors who felt they had more understanding of situations following their personal experiences. What did not seem to happen, except in these three examples was a move that took the health visitor outside of the binaried position that I have suggested is inherent in the practitioner-client and into a relationship which is woman to woman or person to person.

The deconstruction described in this section has shown how gender can be hidden within a taken-for-granted view of the practitioner-client relationship. An argument has been created which shows how an alternative practice could emerge if the binaried relationships in health visiting were identified and more self aware positioning was part of the socialisation process for the work. This in turn might assist in a more positive relationship between health visitor and client in which surveillance could be subsidiary to a mutual basis in discussion with experiences and caring being heightened. Although social regulation and social control have been accepted in this thesis as relevant to health visiting, it is argued that this is from an external view of the work. The internal view that is evidenced in the data is that there is dissonance with this view in favour of care and connection, emotional labour and shared experiences.

Conclusion

A tension between the surveiller and the reciprocal connected relationship has been explored in this chapter. What has not been explored in this study is the question as to whether or not health visitors have concluded that their role is not working well within the euphemism of ‘invisibility’. There is current pressure to re-define health visiting in terms of public health work and this will be considered during the final chapter. A further point to raise is the suggestion that a collective ideological challenge could be mounted by health visitors in an effort to make obvious the process of their work at a deeper level and in the context of care and caring as a social dimension of health visiting. The feasibility of this within policy and curriculum will be debated with other issues in the concluding chapter and links with the debate on the potential of transformation which was explored in the previous chapter.

CHAPTER EIGHT

CONCLUSION : A NEW VIEW FOR HEALTH VISITING?

Introduction

This thesis has been concerned to describe and analyse the aura of invisibility which pervades health visiting, and it is now appropriate to draw some general conclusions from the evidence presented here. In particular there is a need to consider the place of health visitors and health visiting practice in terms of wider notions of health care practice and women's work with other women, and hence the role of the health visitor and invisibility in the context of feminist understandings. This research has been concerned throughout to hear the ways in which health visitors express their views about themselves, and their work with women, within feminist theories from care and caring, knowledge development and power relations. It has questioned the undervaluing of health visiting through examination of invisibility as a reality in the work and as a metaphor. It has sought a relationship between the health visitors' work and the place of invisibility by utilising particular feminist theories and discourses as tools for analysis. In the previous three chapters there have been many interwoven extracts and commentaries from a variety of female health visitors that reveal dichotomies in practice and a diminution in their place as women, who are practitioners, in a gendered work place. It is in these paradoxes and diversity that the heart of the thesis is found.

The picture that has unfolded is one of public accountability based in outcome measures that have a factual basis in the preparation of health visitors. At the same time there is a process of work which draws on connection with women and utilises personal experiences as a resource. There are tensions in the individual management of these processes, which is seen in the way they are minimised and spoken of with caution and with caveats that devalue both gender and experience. The issue of invisibility has been seen as a reality and as a metaphor that disguises or hides crucial aspects of practice. The story which has unfolded is of health visitors recognising themselves as women with life experiences, who care about the women they visit, but without a framework within which to place these parts of practice. This is discursive to the body of health visiting and the study has contributed some transparency to the processes not usually explored. The power of a metaphor to influence meaning was recognisable through the common assertions that health visiting was 'invisible' to many. Therefore the following statement by Mezirow needs also to be taken into account in the discussion.

[Chapter Fifteen] introduces educators to an analysis of metaphors, which we use not only to describe and explain but also to *construe* our experience. It is often crucial that we become aware of how we have unwittingly permitted the metaphors we use to create meaning for us. (1990:xix)

This thesis argues that there are levels and layers of invisible processes in health visiting which have contributed to the way in which this metaphor has unwittingly reinforced the belief in health visiting being 'invisible'. Three types of 'invisible' process will be used in this chapter to provide an integration to the previous

chapters and to conclusions and applications drawn for practice. Additionally, these processes will be contextualised within the overarching structure of each chapter where data was presented and explored.

There was no health visitor who considered work with women to be outside of their remit. All the participants drew on their own experiences to connect with some women in the activity of health visiting. The majority readily gave examples which showed how their own life experiences had contributed to their work, and the one or two who initially resisted this as a possibility found that there were ways in which their own life experiences did make a difference. However not all participants appeared to utilise the connection as though they were women, nor to acknowledge that their activities were specifically with women. There appeared to be a paradox that even though they are women, the health visitors in the study chose to offer a 'service' rather than 'themselves' in their work and at the same time neither did they speak of their clients as 'women' but as 'people'. Bearing in mind the assertion that a metaphor can be a way of construing meaning and the assertions by the participants that health visiting is nebulous and invisible the suggestion here is that by the diminution of gender within the work, the health visitors contribute to their own invisibility. By contrast, that which is visible are the activities and topics which can be coded and yet these seem to be dismissed when compared with the need for quality.

1 HEALTH VISITING AND THE PARADOX OF INVISIBILITY

Understandings about health visiting have to take account of the enigma within health visiting as a health care practice which is sustained by health policy but is acknowledged as being without a clear core work. In particular, the health visitor as a woman worker will also be subject to the political ideas of hegemony and masculinity (Connell 1987). In a National Health Service which increasingly emphasises the positive benefits of ‘value for money’ and ‘evidence-based practice’ and ‘clinical governance’, it is not surprising that health visitors focus on the products of their work required for coding and data collection by managers (Adams 2000; DoH 1999c).

However, a puzzle which the health visitors in this study expressed with regard to their work can be located in the positive images of care and caring which are part of the processes of health care practice. The desire to be valued for this part of their work arises in part from the strength of such imagery. Moreover, care and caring present themselves as part of the ‘relationship’ in health visiting which has been noted as a means to achieving health targets (De la Cuesta 1994; Chalmers 1992). The accounts which have been presented indicate an uncertain dimension to this through the ambiguous way in which personal experience and knowledge gained through this, could or could not contribute to the health visitors’ work with women.

Although an integrated approach to health visiting presents a goal to strive for, even if not actually acknowledged by the managerial systems, the health visitor is beset by contradictory images. On the one hand they hold a positive image of objective and scientifically derived knowledge for practice and yet on the other hand they have subjective and relevant experiences, similar to the women they visit as clients, but they have no remit or model of practice to utilise this material.

The role of a woman's experience, as a health care practitioner visiting other women, is therefore relegated to an anomalous position. It becomes irrelevant, unacknowledged and thereby invisible. The paradox within this situation is that being a woman can be dispensed with and a neutral service, without gender connotations can be offered to women clients. The desire to provide realistic support to clients forms part of the positive imagery in health visiting and personal experience provides a resource for this. Thus a contradictory position in this has evolved in which health visitors have managed to draw upon their personal 'situated knowledge' (Haraway 1988; Davies C. 2000) and accept situated knowledge as a universal teacher, yet at the same time deny its importance or reality to other health visitors or clients. The paradox of being a woman worker in this situation forms part of the problem of the 'invisible' health visitor. In order to judge its more specific relevance there is a need to consider its relationship to the ways in which the 'invisible' could be made more visible. This was achieved through application of

feminist theories and feminist analysis by bringing the less visible aspects of health visiting practice into the foreground through feminist analysis.

In this concluding chapter I have described three forms of invisibility which have different but overlapping meanings in the practice of health visiting. These variations on invisibility were blended within the analyses presented in the preceding three chapters and therefore the conclusion will provide an integrating function to the whole work. There will be a slight emphasis upon each chapter in the following commentary and for this there will be a reverse order for reasons which will become apparent in the analytical framework used to inform this final chapter. The model I have used as a unifying feature follows ideas from Edwards and Ribbens and the comments I make therefore need also to take account of their position and the following statement

...we have examined 'private' and 'personal' social worlds, which we then make 'public' for academic, and perhaps professional, audiences. Such projects have 'liminal' connotations, in terms of being 'betwixt and between' the dominant social and symbolic classification systems of public knowledge, and less visible and vocal understandings found on the more personalised settings of everyday living. In this way, we find ourselves on the margins between different social worlds. (1998:2)

For heuristic reasons I will distinguish the 'invisibility's' by making a distinction between public work and its dilemmas with transparency, with private lay knowledge and with personal emotional and feeling knowledge. The invisible

worker is the first form of invisibility which I describe and because of the way it pervades the work environment I will refer to it as a 'public' invisibility that is ascribed by others about the health visiting role. The next form of invisibility I present is concerned with the invisible woman within health visiting, somewhat separated from the practitioner within her own lay knowledge, and will refer to this as 'private' invisibility. The third form of invisibility is the hidden, feeling work which does not receive recognition through the codes which account for health visiting contacts with clients and which I will refer to as 'personal' invisibility.

In so doing, I am aware that these terms only broadly signify the distinction and meaning of the metaphors concerned and the place of the health visitor in relation to them. In particular, it should be noted that each form of the metaphor operates in each setting, both publicly and privately and personally. Moreover, they do so separately and in combination and their various combinations which include the edges of visibility and knowledge where there are imperceptible shifts of awareness needs to be remembered. In addition, by giving specific terms these tend to mask the social and epistemological nature of the metaphor as a device which can affect meaning. Although there are aspects of masking which contribute to ambiguity in the world of the health visitor, nevertheless, some of these features will be made clearer as consideration is given to each of these variations. Learning to unmask the power of 'invisible' as a metaphor is a challenge to health visiting as an outcome of

this research. Reference will be made to the ideas, values and beliefs which the meanings contain and their place in the practice of health visiting.

2 THE METAPHOR OF ‘PUBLIC INVISIBILITY’

The public position of health visitors as ‘invisible’ workers is without doubt one of disquiet to health visitors. It has been seen that this is concerned with the difficulty experienced by others in defining core work (Smith J 1996; Davies C.1997; Elkan et al 2000a). However it has also been apparent that health visitors themselves perceive their work as invisible and nebulous, hard to describe and colluding with outsiders who tend to undervalue the work through its lack of clear definition. The metaphor therefore illuminates the pervasive nature of this situation in the work and practice of health visiting. It is through this illumination that the metaphor of ‘public invisibility’ provides an insight into the complexity of health visiting which cannot be dismissed by easy explanations and quantification through computerised data base systems.

The form in which the metaphor provides illumination is specifically by telling health visitors that their work defies analysis and has, in the words of Mezirow, created meaning for them. This leads to a situation where health visitors and their managers have to devise various ways to overcome its demoralising message. The

power of the metaphor is seen in its effectiveness. Health visitors maintain their stance that the job is hard to define (Traynor and Wade 1994); the Department of Health provided a marketing tool to enhance visibility, thereby confirming that the work was 'invisible' (DoH, England 1994); and managers have introduced codes to quantify the work and reveal its content (DoH 1989). In addition one professional organisation obtained government funding to support an investigation into what might be the core functions in the 21st century (Office for Public Management 2000). It would be encouraging to say that health visitors go to great lengths to ensure visibility but the opposite appears to be the case, with the maintenance of a cloak to hide within and resistances set up against commentary that challenged the traditional work with healthy families with adequate parenting (Audit Commission 1994).

Since the public domain is characterised by being 'goal-oriented and individualistic in its overt value system, and its way of being and knowing' (Edwards and Ribbens 1998:14) it is the issue of quantification which needs, first, to be addressed. For the health visitors the national management strategy of coded data raised an awareness that outcomes such as referrals and numbers of activities such as immunisations would constitute an ongoing surveillance of their type and volume of work. This was at variance with previously held values about the relationship with managers and the quantification and management of work loads. Specifically the need to work to targets, those based in The Health of the Nation (Great Britain,

DoH 1992) and those made in respect of numbers of contacts contracted through General Practice Fundholding, brought 'into the light' a pressure to work in a particular way in order to achieve the targets (DoH 1990).

This pressure to achieve, as a way of viewing and knowing about health visiting, offers a route towards identifying core work and making visible the attainment of that work. Its cost, however, is that it focuses exclusively upon the product aspect of the work, and prepares the way for as much measurable work as can be proposed by the State in its attempt to produce a clearly defined role. A further cost could be envisaged through the process of care becoming a commodity, which then loses its relationship dimension and becomes part of the oppressive quantification which it has been attempting to avoid. A dilemma is that in seeking to be more visible, the care element raises the issue of women's work and the prospect of keeping women in particular roles within an essentialist position. This issue will be returned to later in the chapter.

Currently, measurable work is being debated in the context of a public health role, for which the term 'public health nursing - health visitor', provides an entrance (UKCC 1998). Public health is a core feature of the new NHS and its modernisation programme under the Labour administration. The pressures noted in chapter three and in chapter seven provide a powerful force to drive health visiting forward into a more substantial and transparent activity through these more medical

and goal oriented activities. It is hard to resist the rhetoric of improving health, saving lives and caring for the vulnerable through 'Our Healthier Nation' targets and priorities (DoH 1997; 1999c). Health visitors received specific mention as public health practitioners, together with school nurses, in Our Healthier Nation and were informed through this document that the government is 'modernising the role of health visitors', and that 'health visitors will lead public health practice and agree local health plans' (DoH, 1999c:132,133). Other policy documents show a direction for a health visitor as 'consultant' and as providing leadership in public health and primary care (DoH 1999c; DoH 2001). In addition specific public health orientations are seen in targets for geographical areas where ill-health and inequalities are identified through the Health Improvement Programmes and partnership activity in Health Action Zones to develop new ways of working to improve health and reduce inequalities; also parenting support through Sure Start schemes (DfEE 1999).

These traditional activities, albeit with a heightened focus and visibility through policy documents will perpetuate the dominant, masculinist and gendered view within the NHS (Davies C. 1995; Mayall 1990) and the larger hegemonic context of society (Connell 1987; Pascall 1997; Pilcher 1999). Thus the rhetoric of family, parenting, homeless people and social isolation in the policy documents, still upholds the power to name the focus of work and at the same time hides the less acceptable reality of women and their particular need; the only 'women' who were identified

for health improvement activities were 'breast feeding mothers and women at risk of post-natal depression' (DoH 1999c). New public health which incorporates social health models finds many advocates and could therefore be attractive to health visitors educated in health and social models as well as medical models (Colin-Thome 1993; Billingham and Perkins 1997; Watkins and Wilson 1997; Thomas 1997). By contrast, more medical and illness related opportunities for health visitors are also being promulgated, for example with breast cancer (Lugton 1997); with community child health nursing (MacGregor and Hellings 1999) and parent counselling in child mental health (Davis and Spurr 1996).

Visibility, through targets and pre-specified work, was not seen in a favourable light by the majority of the health visitors. They sought to continue defining their work through 'quality' not 'quantity' and in less technical and medical work. Nevertheless the data showed health visitors recognising that these were ways forward for the maintenance of their jobs, and for the future trends in health visiting. Quality was an activity which was hard to define and it appeared integral to the nebulous aspect of health visiting. Therefore, to fully accept visibility through codes and quantification would be to deny what many health visitors would call 'health visiting'. This was precisely the health visitors' criticism of the findings in the Audit Commission (1994), which has been used throughout this thesis as an objective window onto health visiting practice. Additionally, the collection of data through

codes and computer aided systems is not neutral; by its forced-choice categories it inevitably alters the activity which it was designed to reflect (Cowley 1993).

When these features are considered in combination with the criticisms of health visiting performance with clients, it is vital that a change of outlook is secured in order to match perceptions of 'quality' and 'production'. There is little in the current practice to provide confidence that this would occur, but there are indications of a potential when analyses of elements of the process of health visiting are taken together. There is complexity here and a measure of ambiguity, nevertheless there is also some enlightenment when the 'private' invisibility in health visiting is examined.

3 THE METAPHOR OF 'PRIVATE INVISIBILITY'

Through the data it has been seen that health visitors construct various meanings about the process of their work and in particular the value placed on a shared background with their clients and a sense of relationality, seen in both chapter five and chapter six. Themes linked both with care and knowledge through experience form a key aspect to this somewhat ambiguous understanding of health visiting which is far less visible than that just considered within public invisibility.

Nevertheless this kind of invisibility finds considerable affinity with statements made about the private domain of activity. This has been ‘characterised as more process-orientated and connected in its value system and its way of being and knowing’ (Edwards and Ribbens 1998:14) and sites include friendship, social networks and lay knowledges. In respect of research into childbirth this is enlarged to incorporate ‘lay knowledges of childbirth made up of informal interactions between women and ... friends...’ (Miller 1998:59). From a different perspective this can be seen as ‘mutual meaning’, where there is a shared understanding in dialogue through which intentions and expectations can be clarified and developed (Morton-Cooper 2000), whether in the learning support environment or in this context of health visitor and client dialogue.

Although visiting clients as ‘health care workers’ and therefore in a ‘professional’ public role, it became evident in the data that health visitors were themselves ‘women’ drawing on their gendered experience as women, but they were also seen as contradicting this when viewing health visiting as a service commodity. They appeared to be deeply influenced by their childbirth experiences and in a remarkable way revealed this as ‘lay knowledge’ available as a resource to themselves as ‘the professional worker’, although it did not generally feature as an available or visible resource to the clients. This lay knowledge was not confined to childbirth but extended to other life experiences such as bereavement and unemployment. However, as a resource, this lay knowledge gave increased insight of a private

nature to the activity of health visiting, that is to the process dimension rather than the public output of achievement. Thus, it had an effect of a qualitative nature on the work, perhaps one of the elusive dimensions of quality that are not measurable nor standard features of individual workers. This research has therefore uncovered new insights into a private resource brought to health visiting through health visitors' own lay knowledges. In addition, the research reveals an intersection where a gender free view and a gender active view can converge and produce new knowledge. This intersection also shows how lay knowledge from private experience within the scientific background could make a powerful contribution to women, if seen through a woman-to-woman relationship rather than the hierarchical and advice giving role.

It would not constitute normal health visiting for health visitors to disclose or discuss their own shared experiences in a 'friendship' fashion which was evident in the data. However the friendly relationship and the historical position of being both a 'friend' and a 'surveiller' requires a comment (Davies C.1988). There is little doubt that the relationship in health visiting is regarded as important and many health visitors viewed it as ongoing, which I termed as a dormant relationship and part of the connection thesis in chapter five. Because the prevailing view is that the relationship 'never ends' it therefore must be seen as a significant contributor to the way health visitors view themselves in relation to this more private part of the work.

By contrast, and more negatively, the ongoing view that ‘mother’s friend’ is part of health visiting, must in part be a myth when seen from the client’s perspective as seen in chapter seven within the debate about surveillance and resistance. Indeed, this aspect of ‘mother’s friend’ has been seen as part of the social regulation of health visiting through the way it introduces an informal and voluntary aspect to the work and therefore it ‘serves to mask the nature of the relationship which is being forged’ (Peckover 1998:72). The role of the State can be seen at the centre of this and the direction into measurable public health work as previously discussed. Indeed the prevailing argument by Peckover, is that health visiting is gendered and unaware in its stance towards women and with little evidence of knowledge about social divisions and anti-discriminatory practices.

This research did not contradict this but showed a different way of viewing health visiting activity through the potential for transformed knowledge based in feminist understandings of women’s development, experience, and care. Given that the health visitors in this study exhibited care, caring and connection without a clear model within which to place it, this thesis argues for professional debate to make visible and examine this within a framework that provides illumination about women’s development and the gendered nature of health visiting. Although somewhat patronising as a statement, ‘mother’s friend’ (Davies C. 1988) could

provide a focus for deconstructing the issues of relationality that are contained within a transformed view of women visiting women.

This deconstruction would need to take account of the critique of the ethic of care which argues that by placing women in the caring role, the essentialist position is re-asserted and would result in a reduction of the feminist ethic of care as a counter discourse. In this context it would link connection and relationality, into the view that caring is innate to women and further reduce its contribution to the feminist emancipatory project. Additionally, connected relationality can be seen as having the potential to become a new oppressive discourse (Diller 1996). However, there are counter arguments to the difficulties raised by fears of essentialism in which it can be viewed as an analytical and political dead end (Tong 1998). Other views support the need to 'by-pass' essentialist fears are that feminists must take 'the risk of essence' in order to think differently (Barr 1999 : 74) and that utilising care as a means for change 'cannot necessarily wait for feminist theories of care or of an ethic of care to be provided to our satisfaction' (Larrabee 1993 : 16). There is agreement in this thesis that there are concerns about essentialism which could occur by raising the profile of care and caring in health visiting. However, the more necessary position for health visitors, is that it is necessary to broaden understandings of the meanings of care, seen in the deconstruction of care by Tronto (1993), and in the need for agency by health care practitioners and policies of care that provide a different orientation in practice (Sevenhuijsen 1998).

The theoretical perspectives underpinning this study have drawn attention to the lack of discourses which inform the practices of health visitors in their ability to relate themselves to the work as women; this has a number of policy and practice implications regarding future education and training. Health visitor education and practice is shaped by a number of competing discourses which have contributed to the lack of clarity about the core work and blurred the way forward with its competing directions of community oriented public health and more individual health enhancing models (Elkan 2000a; Cowley 1999). Furthermore, it is argued here, that the distinction between children and women are viewed as having competing needs. Curricula, as driven by local practice needs, continues to be dominated by discourses on children's health and development; whereas feminist discourses on motherhood, single parenthood, child abuse and male violence may not be included in favour of malestream and conservative outlooks about women and health (Mayall and Foster 1989; Abbott and Sapsford 1990). In particular there is a stereotypical view of the health visitor as 'middle class, dressed in twinset and pearls', alluded to as such by one participant. As a health visiting discourse, this stereotype excludes by its strength, any discourse which suggests that a health visitor might be a single parent, be subject to violence or in any other way experienced in distress. A further outcome of such a discourse is that such behaviour is not readily identified or understood by the health visitor in relation to her clients (Peckover 1999; Frost 1999; Knott and Latter 1999). In addition there is some evidence accruing that health visitors may be less aware of women's needs in

post natal depression than would be considered likely since there has been a steady recognition that working with post natal depression is health visiting work (Higgins 2001).

In order to raise health visitor awareness of the needs of women rather than the needs of children there will need to be a redirection of the curriculum to achieve this. It could be related to the 'search for health needs' activity of health visiting (Council for the Education and Training of Health Visitors 1977) which gives legitimacy to search for unidentified health needs. The fact that health visitors appear not to recognise women's experiences of need, is an evidence of the continuation of the dominant and prevailing views which have kept such issues hidden. It is further suggested that a cultural studies curriculum (Lawton 1983; Probyn 1993; During 1993; Ingham and Hardy 1993) would provide a broad base from which to develop awareness of alternate positions and lifestyles in gender, class and race. This would also contribute greater knowledge of specific health needs. Furthermore, by utilising feminist understandings of knowledge creation a mechanism for using personal lay knowledge as part of a transformed professional invisible resource would be developed.

4 THE METAPHOR OF ‘PERSONAL INVISIBILITY’

The personal domain is conceptualised as ‘a way of drawing attention to experiences that are constituted around a sense of self or identity, to do with emotions, intimacy or the body... it concerns the social as ontologically experienced by the individual; that is in relation to a person’s own sense of being or existence.’ (Edwards and Ribbens 1998:14). Unexpectedly the data revealed personal experiences were shared as dialogue with clients and were also an internal dialogue or feeling in respect of emotion and interaction with clients in varieties of ways. This kind of invisible contribution to the work was seen in care and emotional labour within chapter five, as well as through experience and knowledge creation in chapter six and also within chapter seven in empathic ways of relating and reduction of the binaried pairing of professional-client. This understanding of a further level of invisibility is a continued demonstration to the way feminist understandings and theory have contributed new ways of viewing health visiting activity through this research.

All the health visitors had examples of personal life experience which they recognised as useful resources in their work, although this was generally surrounded with caveats of caution. This personal sharing is at the boundary of what is

recognised as 'professional' activity and can be viewed as part of the 'private invisibility' discussed in the previous section. However it is also at that threshold where the personal experience is transformed from a recognised situation into being part of the individual identity with which the health visitor relates to the women she visits in the home, or has contact with, in the health centre or the general practice premises. This boundary can be seen as the margin which allows the 'betwixt and between' and the 'liminal' connotations described in the quotation from Edwards and Ribbens earlier in this chapter. The evidence from the data pointed to health visitors exhibiting care and emotional labour in a taken-for-granted fashion and without recognition that this was intrinsic to a gendered identity. The description of a personal domain locates its centre with emotion and ontological dimensions and by implication to relationality and connection discussed in chapter five.

This research highlights a gap in curricula for women workers by the omission of gender studies and in particular the ways in which women can become aware of their gendered identity in society and how this might contribute to care for self, individuals and the community (Probyn 1993). It is also argued, by Probyn, that there is an ontological and epistemological tension that can intersect in ways which reveal awareness of what it is to be gendered, seen in the questions of 'who am I and who is she?' (Probyn 1993:168). Increased ontological awareness in this way could lead health visitors to a transformed view of the women who are their clients. It would challenge the uninformed view about the varieties of non-standard need

within an hegemonic society and also the policy which upholds 'family' and has expectations of a kind of standard in 'parenting' that health visitors might customarily uphold.

These are invisible values which influence the work of the health visitor and it can be seen that there are ways to make them explicit through gender studies and the incorporation of a language to discuss them. The issue of, and need for, a language has been raised a number of times through the study, in particular with respect to emotional labour and to an analysis of care. These will be considered separately although there has been the common need for ways to articulate this aspect of the work. Both concepts and activity are developed in new ways in this research as a further contribution to an understanding of health visiting. Although of recent antecedents the literature and research into emotional labour and the language of emotion continues to be developed, including its visibility within primary care and divisions of care in which the 'The image of a 'family' is used to reinforce the gender stereotype of the subjective female (nurse) and objective male (doctor) that is widespread in society' (Smith and Gray 2000:46). The use of the language of emotion has gained some recognition in politics, not always favourable (Mayo 1999) but is receiving positive attention through the concept of emotional literacy. Emotional literacy within learning environments has been described in the following way:-

When we are talking about EL [emotional literacy] we are talking about using our knowledge to insist on the grave consequences of emotional illiteracy which result in social and personal breakdowns and the collapse of social capital. We are talking about violence, child abuse, interpersonal crime, self harm, homelessness, no-go areas, school exclusions, bullying, political posturing rather than thinking, understanding, work environments that exploit rather than engage employees, racist attitudes towards refugees, fundamentalist modes of thought which offer certainty in the face of complexity and when all is said and done a hostility to human emotional life. (Orbach 2001:7)

This description epitomises many of the dimensions of health visiting which need enhancement, not only in the way that women's needs are identified, but also in awareness and action towards other people who are disadvantaged within health care systems and could be identified through health profiling which is part of the more public work. In turn, it is advocated as part of curriculum development towards more ability to manage emotions in the work place and the reduction of the 'scientific rationale' that has been endemic to health care work (Morton-Cooper 2000:30). In addition, this debate seeks to ensure adequate emotional support for individual practitioners, both through increased education about emotions and their management, but also through professional support mechanisms of clinical supervision, preceptorship and mentoring.

It can be seen from this commentary that there is a link back to the whole issue of care and caring. In chapter five, the case was made for a framework to articulate care in ways which would be commensurate with health visiting, as well as finding a place for the concepts of caring, emotional labour and connection. Thus it is argued

that health visiting is predicated in this dimension on two types of care activity. One which is objective and linked to social need and the need to articulate that through a 'care analysis' and plan for individuals and community. The second is subjective and linked to the self and the emotional labour that is a real activity in working with all people, although in this context, mainly with women. The two can be drawn together in the words of Probyn 'The care of the self thus can only be conceived of and performed within the exigencies of caring for others and for and within our distinct communities' (1993:169).

The metaphor of invisibility has been an appropriate mechanism to reveal the complexity of health visiting in three separate but related ways and has fulfilled the original aim of uncovering and making transparent the more hidden aspects of health visiting. The value of applying a gender lens and the use of feminist concepts have shown how health visitors undertake their work on a number of levels which operate simultaneously but not always in harmony. In order to enhance practice with women clients this thesis makes the point that health visiting needs to accommodate these three levels in which they work. Therefore the final part of this chapter will draw all aspects together to link practice, education and feminist thinking within a changed potential for health visiting.

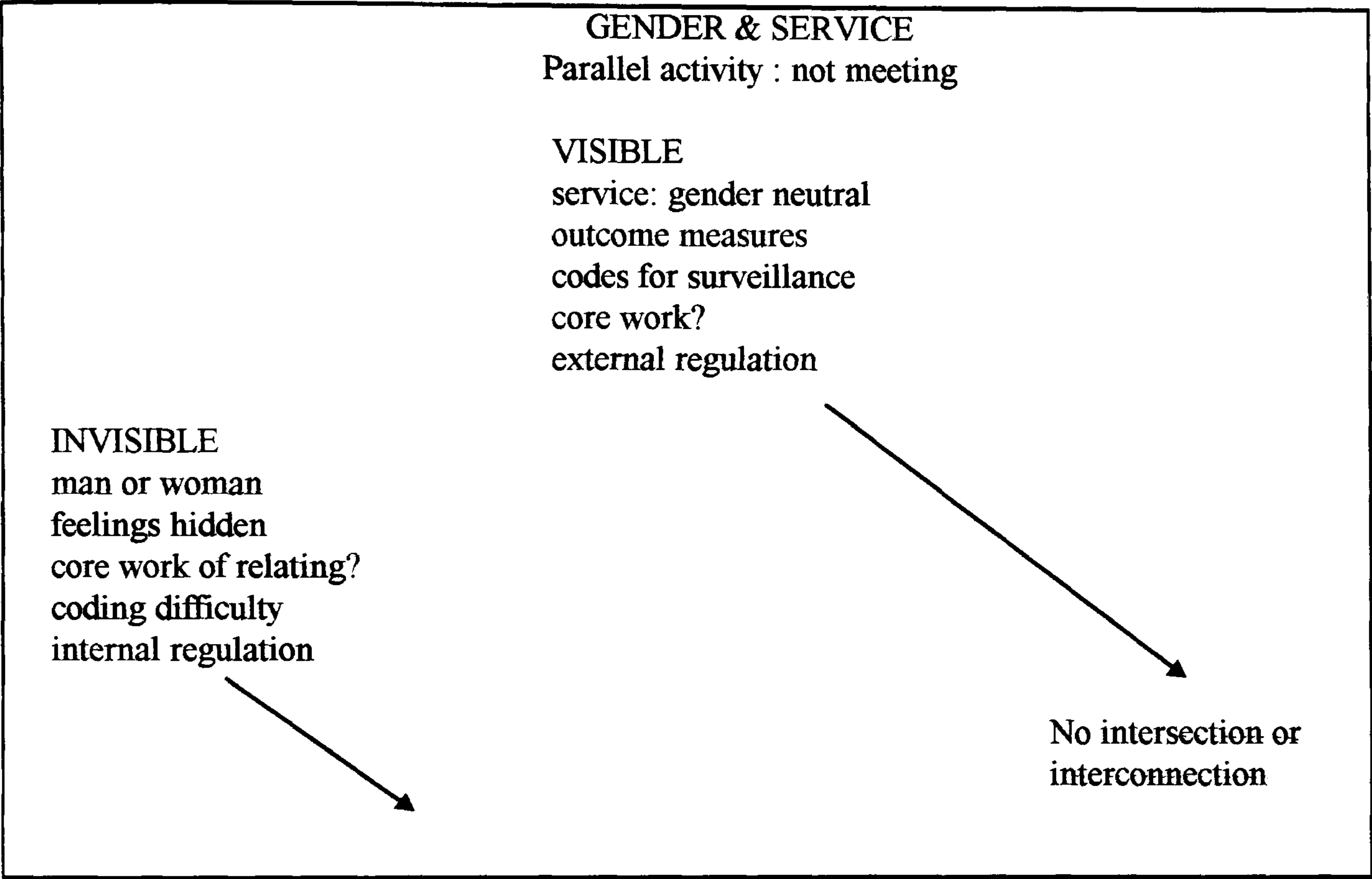
5 INTEGRATION AND SUMMARY OF NEW VIEWS

The intersection of one mode of learning with another has been seen in a number of places in this chapter and in previous chapters, to provide a way forward for a new or transformed view of a known situation. In particular this was discussed in chapter six in respect of the transformations which take place when science and experience converge. In addition to the ways in which invisibility have been explored, three summary statements are useful in clarifying the overarching contexts within which public, private and personal invisibility are placed. Taken in this same order of public, private and personal and based within the three chapters in reverse order, they are represented as ‘gender and service’, ‘science and experience’ and ‘connection and care’. These are represented below in diagrammatic form and the link with feminist theories is indicated although not expanded.

Gender and service, figure 4, shows the visible and invisible dimensions as parallel activities and that intersection does not take place when the practitioner remains in the gender neutral position, by personal internal regulation, and is subject to external regulation. This illustration, which draws upon chapter seven, reveals a dilemma where a ‘service’ with outcome measures is provided but where the practitioner as a ‘person’ has little value for outcome measures. This perspective incorporates feminist views of the invisible worker (Graham 1983; Smith D. 1987; Mayall 1993) which this research seeks to overcome through integration of the public, private and personal domains in ways which could be utilised by the health

visitors. This in turn should be of benefit to the women clients. This binary could be overcome by other constructions using a feminist orientation (Davies B. 1997a) within an educational framework.

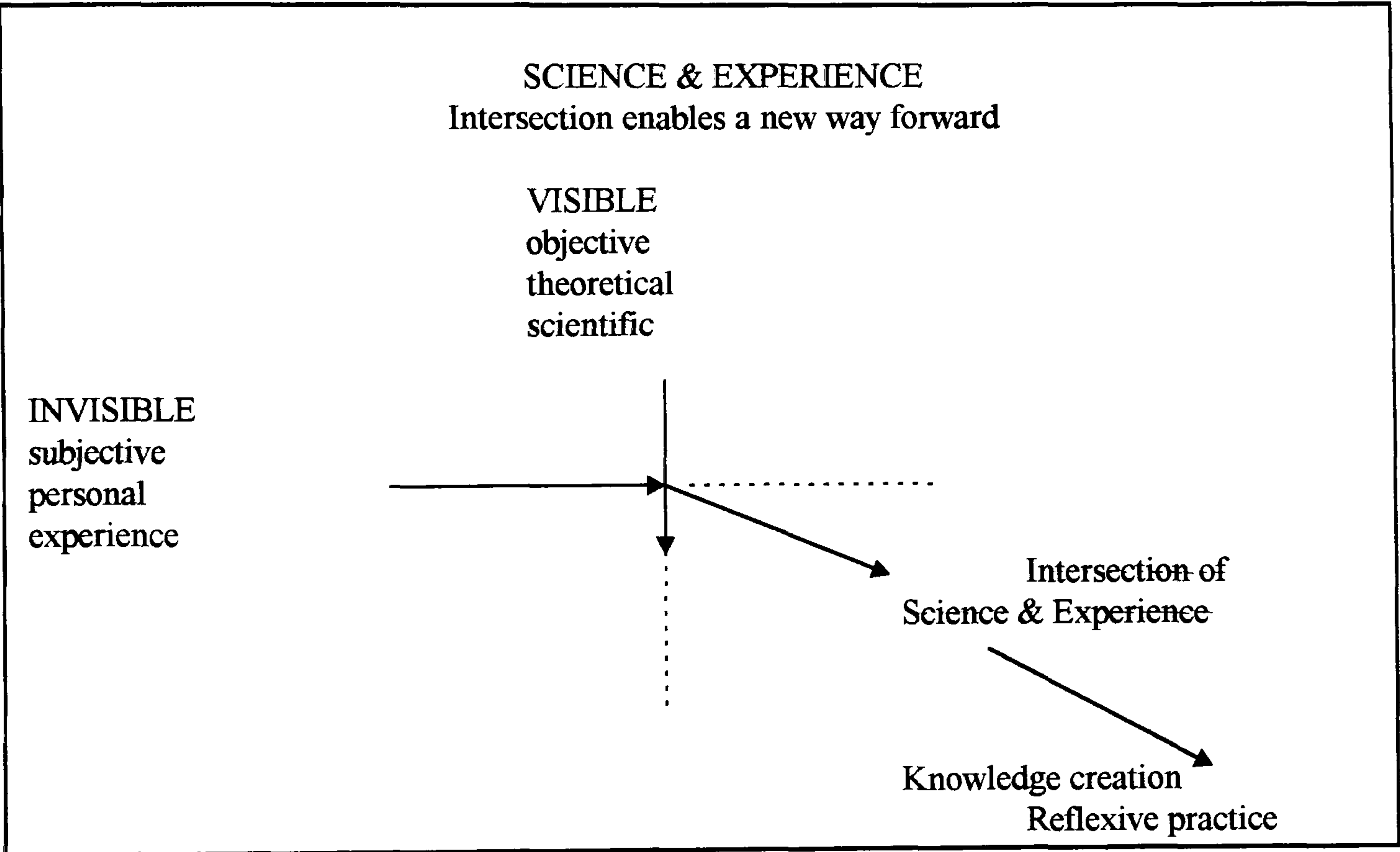
Figure 4 : Invisible and visible work as a parallel activity



In contrast, the summary illustration from chapter six, reveals the goal of using evidence-based practice through the scientific mode but provides a way of utilising the private and the personal experiences through new knowledge creation, figure five. This can occur when the intersection of these are acknowledged and integrated which then provides a place for both visible and invisible aspects of practice.

Although this process has a link with reflective practice, it would be essential that the paradigm underpinning this activity would illuminate feminist understandings, otherwise the dominant model of epistemology would be perpetuated (Harding 1991). Women’s experiences need to be utilised in knowledge creation (Blackmore 1999; Lewis 1993).

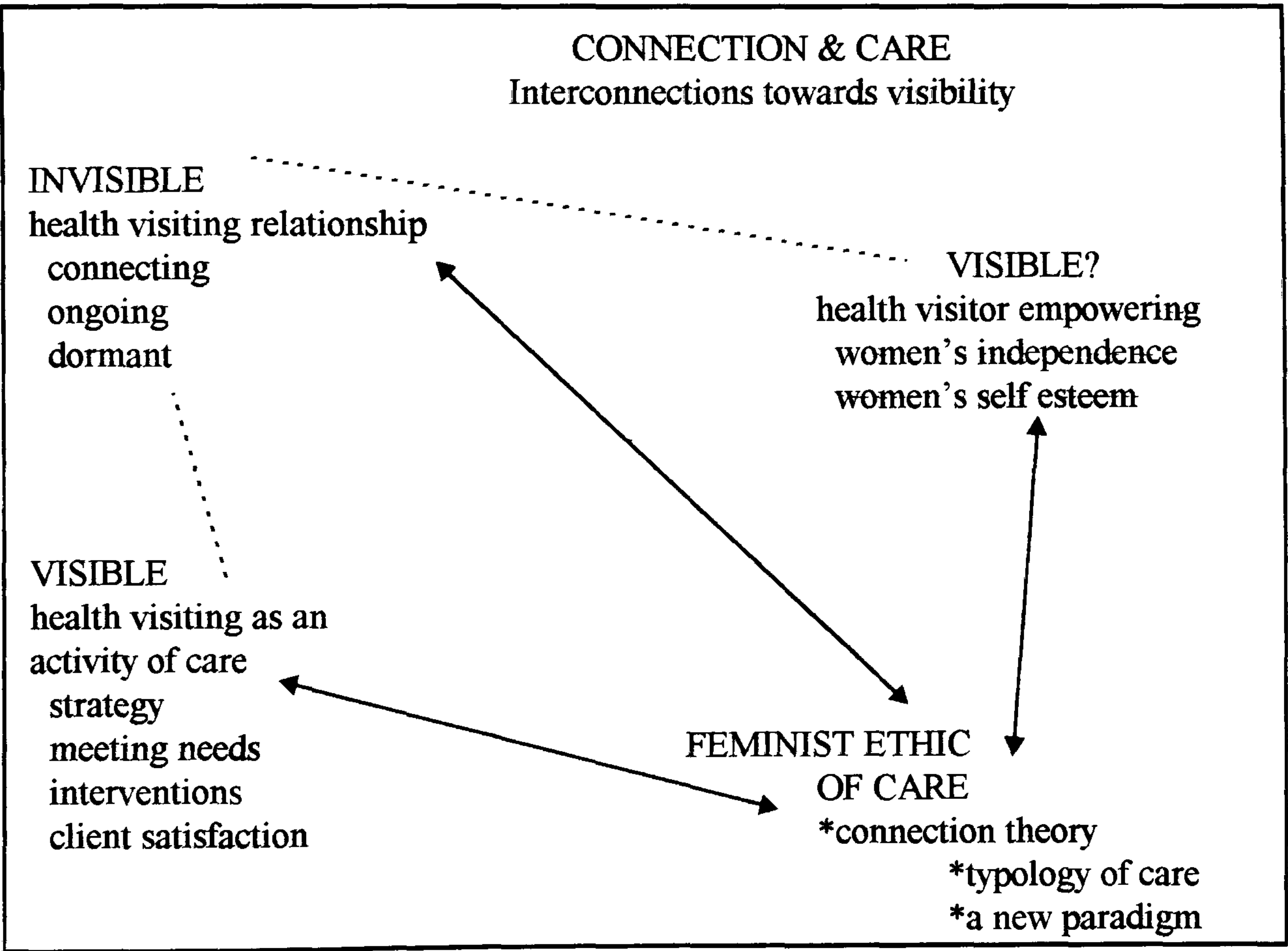
Figure 5 : Transformed knowledge where invisible and visible work intersect



The third illustration shows that the health visitor does connect with the client through the relationship but this remains a tacit activity and therefore an invisible activity although is a real emotional exchange with clients (James 1989; Smith P 1992; Smith and Gray 2000). Chapter five argued for care to be made more visible

through a care typology and suggested a place for care both as an individual and as a political activity which could then have a visible arena; these aspects are integrated to the concepts identified in a feminist ethic of care and connect through a two way process (Tronto 1993; Sevenhuijsen 1998; Gilligan 1982). It also argued for women’s development being viewed in ways which included connection and a relational web (Ferguson 1988; Griffiths 1995; Shrewsbury 1998). This is shown in figure six.

Figure 6 : Interconnections between invisible and visible activity



The complexity of working in these different ways has contributed to the lack of clarity about the work. It does appear as though in practice health visitors do have a

hidden and thus invisible mode within the process of their work. This thesis upholds the view that the invisible processes should be made more transparent. An opposing lobby might argue for the reduction of this part of the work and for a clear and visible work focused entirely in the technical aspects of child health surveillance and the identifiable features of public health. It is argued that this would perpetuate the lack of definition and identification of women's needs within the health care system which are currently accessible by health visitors albeit not identified by them through the search for health needs activity. The issue of how to produce this change is now the focus. The current discourses in health visitor education need to be reconsidered for a different model of knowledge, which this thesis argues should be based in feminist understandings and gender analyses of organisations and relationships. Thus a more equal and productive view of women's needs would be gained with the consequent reduction of the 'advice giving' mode and its resistances by clients.

It is firmly acknowledged that this not neutral. An interesting question was raised 'Is knowledge neutral?' (Symonds 1998) and the reply from these conclusions and recommendations is that it is not neutral and that it does perpetuate past patterns. It therefore gives meaning for particular times and events and has been seen through the debates in this thesis to require transformative processes in order to produce a new view. The discourses which contribute to health visiting need, therefore, to be reconsidered on a corporate basis through the curriculum and through practice, as

well as individually with intending health visitors. One way to move in this direction would be to further the debate which would separate health visiting from nursing, with its particular sets of power relations and emphasis on caring as its focus (McCance et al 1999; Haughey and Cowley 2000). A second way would be to introduce gender studies and women's needs as a core curriculum within the current syllabus. However, evidence suggests that introducing new discourses, even 'liberatory curriculum' encounters resistance (Lather 1991:123) and yet without this there appears little prospect of change. The only other feminist analysis of health visiting has strongly asserted the need for domestic violence to feature highly on the health visiting agenda and the need to change the professional discourses about male violence and motherhood (Peckover 1998). However unless this is supported by clear transforming understandings this will remain at a 'training level' and will not provide new and more equal ways of relating to women which has been central to the evidence provided in this thesis.

The overall picture which has emerged recognises the lack of feminist perspectives in health visiting (Orr 1986; Abbott and Sapsford 1990; Rolls 1992) and contributes to the paradoxes felt in health visiting about the nature of 'invisible' practice and a sense of undervaluing. At the same time the gendered nature of health visiting remains the overwhelming paradigm within which the health visitors work (Graham and McKee 1979; Mayall 1990; Peckover 1998). This is seen in the research by Peckover, in which men were seen as 'problematic in health visiting work' and the

work was gendered to the extent that it 'renders men invisible' (1998:224) and fails to place them appropriately in dialogue or in the family. The findings in this study reflect these previous studies in which health visiting has been unaware of the extent to which it is shaped by the dominant discourses whether towards men or towards women.

This study has focused upon health visitors own perceptions of themselves and their work and has made an original contribution by investigating the dilemma of invisibility, which has been seen as a significant discourse within health visiting. In particular it has shown this to operate on three levels and to be related to experience at a private and personal level as well as a public issue linked to the lack of a clear core work. Feminist theories have been instrumental in developing this analysis. The policy and practice implications of the study need to address the core work and the knowledge base underpinning practice. In order to meet women in a manner which reduces 'advice giving' and the hierarchical position of surveillance, this research strongly advocates the introduction of feminist perspectives in the curriculum. This would facilitate a more open response to important issues of disadvantage and distress.

CONCLUSION

This exploration of the views of health visitors about one of their central dilemmas, that is the undervaluing of health visiting, has contributed to existing scholarship. This has been achieved throughout the research which has utilised the theoretical perspectives of feminist theories to illuminate the metaphor and reality of the abstract concept of 'invisibility'. The feminist theories have been in three key areas, firstly those which illuminate interpersonal and community networks, through the ethic of care (Sevenhuijsen 1998) and connection theory with women's development (Gilligan 1982). Secondly through feminist theories which illuminate experience and science in new ways (Harding 1991) and thirdly through feminist poststructuralism as a means of illuminating power relations (Davies B. 1997); the variety of feminist approaches contributes to the dynamic process of research and feminist knowledge (Olesen 2000). All these made it possible to develop new insights regarding processes within the practice of health visiting, representing an original contribution to the existing knowledge base.

The theoretical perspectives drawn from these feminist theories provided the basis for the conceptual, methodological and analytical processes through the research. Although of differing orientations, the common theoretical perspective has been of feminist thinking which in turn has given a coherent means to develop an analysis. Together these have drawn attention to the issues of private and personal experience as a potential resource in health visiting. It has illustrated that using

feminist theories has given explanations for the internal sense of undervaluing and that a dilemma exists because there is no legitimate practice model to accommodate these experiences. This finding has contributed to the overall coherence of the thesis.

This study has provided an opportunity to focus on an issue which has been of personal interest in health visiting, in particular my concern that health visiting could, quite readily, become focused on outcomes to the extent that the invisible process work would not have space to continue. The research has revealed that health visitors work on the boundaries of experience, that there is evidence of transformation and transitional behaviour in which the woman-to-woman work is present but viewed with caution. In particular it has pointed to the need to provide transforming models of practice in order for health visitors to recognise the needs of women from the 'womanly perspective' rather than from the gendered perspective which sets the current agenda for practice orientation.

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APPENDIX 1

INTERVIEW PROMPTS : INDIVIDUAL INTERVIEWS

WORK CONTEXT

- * Thank you for agreeing to participate in my research.
- * I will make a few notes during the discussion, and would be glad if you draw to my attention ideas and thoughts which you think might be helpful.
- * I shall be using pre-planned questions but these can be ordered to suit our conversation.
- * May we start by talking about health visiting practice and work in general?

PRACTICE AND WORK IN GENERAL

1. What do you think is health visiting practice?
 - how have views changed since qualifying
 - what new ideas have you
 - where do women fit in compared to children's needs
- 2 How has your work changed over recent years?
 - level
 - range of work

FAMILY CONTEXT

May we talk about your own family life and how this has changed since you started health visiting

- 3 What changes have taken place in your personal and family life since you started health visiting?
- 4 Can you give me a recent example of a client situation when you drew on your life experience?
 - ensure detail
 - how you think and feel
 - what are common views of health visitors about drawing on this kind of experience
- 5 How do you now feel about dealing with these kinds of situations since your own experience?

WOMAN AND APPLICATION

Lead in conversation about the interest in this section

- 6 Can you give me some recent examples of when you gave more time than usual to a woman rather than talking about child issues?
 - what prompted you kinds of topics
 - what is usual sensitive information plus how you knew women wanted to share it
 - what is not usual

7 In what ways would employers be aware of this kind of input?

output
effective

describe relationships in health visiting
how important is this to employers

8 Health visitors often receive sensitive information from clients. Would you give me an example of this?

ensure detail, how knew wanted to share, would someone else have picked it up, what did with records and use of time, any debriefing of self needed

9 Have you any recent examples of when you felt anxious or concerned for a woman client

how felt

what this did to you personally

job satisfaction in dealing with these issues

any debriefing opportunities

10 Are you able to give me a picture of what this kind of work means to you in its importance?

the amount of time, satisfaction, energy, draining, health education etc.

11 How does working with women's needs rather than children's fit in with health education and other definitions of health visiting?

12 What is your opinion of men working as health visitors?

does it make a difference being a woman service provision

13 Would you describe what is meant by the relationship in health visiting?

14 How do you end relationships in health visiting?

KNOWLEDGE AND SKILLS

lead in conversation

15 What have you learned 'on the job' which wasn't in your health visitor course?

16 In which areas of health visiting do you think you have become really skilled?

17 Which study days or courses have you attended?

development of skills

portfolio

clinical supervision

technical

18 Which courses would you try to attend if they were advertised?

19 Can you think of any other way in which study days of diploma/degree courses could contribute to your work as a health visitor?

20 Before we finish is there anything else you would like to add?

APPENDIX 2

INTERVIEW PROMPTS :GROUP INTERVIEW

- * Thank you for volunteering to participate in my research.
- * I will make a few notes during the discussion, and would be glad if you draw to my attention ideas and thoughts which you think might be helpful.
- * I shall be using pre-planned questions but these can be ordered to suit our conversation.

PRACTICE AND WORK IN GENERAL

May we start by talking about health visiting practice and working with the mothers?

1. What do you think is health visiting practice?

how have views changed since qualifying

what new ideas have you

where do women fit in

RCN Women's Health Care Conference

2 Can you give me some recent examples of when you gave more time than usual to a woman client?

what prompted you kinds of topics

what is usual

sensitive information plus how you knew women wanted to share it

what is not usual

3 In what ways would employers be aware of this kind of input?

output

describe relationships in health visiting

effective

how important is this to employers

4 Have you any recent examples of when you felt anxious or concerned for a woman client

how felt

job satisfaction in dealing with these issues

what this did to you personally

any debriefing opportunities

5 How do you use yourselves as women to help other women?

does it make a difference being a woman service provision

how does working with women's needs fit in with health visiting

PERSONAL AND FAMILY LIFE

6 Have you any examples of life events which have influenced the way you relate to clients?

how you think and feel

how you have changed in practice through this

how you do things

7 Can you give a recent example of a client situation where you drew on this experience?

ensure detail ask for common views held about doing this

KNOWLEDGE AND SKILLS

lead in conversation

8 What have you learned 'on the job' which you didn't learn on the health visitor course?

9 In which areas of health visiting do you think you have become really skilled?

10 Can you describe techniques or methods which work well in health visiting?

11 Which study days or courses have you attended in the past five years?
development of skills portfolio clinical supervision technical

12 Which courses do you think will be the most helpful in the next few years?

Before we finish is there anything else you would like to add or talk about?

APPENDIX 3

Dear Colleague

I am registered with Warwick University in the Department of Continuing Education, for MPhil/PhD research into health visiting and education and I am looking for some volunteers to assist me. The research is about 'process and care in health visiting practice' and I am particularly interested in the interpersonal skills aspect, health visitors' own perceptions and the 'woman to woman' dimension.

The interview would be a fairly informal discussion about different aspects of how you work and some of the ways in which you have changed personally and professionally since qualifying as a health visitor. I think the discussion would be of interest to you as well as a help to me.

I would like to tape the discussion, taking approximately an hour, at a time and place convenient to you. The tape would be transcribed and then erased, and there would be nothing at anytime to identify you or your place of work on the tape or transcription.

Please would you complete the tear off slip and I will make contact with you, or alternatively please ring me at work on the number given above. There is always someone to take a message if I am not available.

Thank you for your interest.

Yours sincerely

Jackie Pritchard

Please return to Jackie Pritchard

Name:-----

Contact Number and best time:-----

APPENDIX 3

Dear Colleague

I am registered with Warwick University, in the Department of Continuing Education, for MPhil/PhD research into health visiting and education and I need to interview a number of health visitors and would very much like to have some volunteers from the group after my presentation today.

The research is about 'process and care in health visiting practice' and I am particularly interested in the interpersonal skills aspect, health visitors' own perceptions and the 'woman to woman' dimension.

The interview would be a fairly informal discussion about different aspects of how you work and some of the ways in which you have changed personally and professionally since qualifying as a health visitor. I would like to tape the discussion, taking approximately an hour, at a time and place convenient to you.

The tape would be transcribed and then erased, and there would be nothing at anytime to identify you or your place of work on the tape or transcription.

I think the discussion would be of interest to you as well as to me, and the analysis should be of benefit to the profession through greater understanding about the processes of health visiting and health visitor education.

Please would you complete brief details on the sheet if you are willing to participate and I will make contact with you in the near future.

Thank you for your interest.

Yours sincerely

Jackie Pritchard

APPENDIX 3

CONTACT DETAILS

NAME -----

CONTACT NUMBER & BEST TIME FOR CONTACT

WORK-----

HOME-----

YEAR QUALIFIED AS A HEALTH VISITOR

APPENDIX 4

INFORMATION SHEET

What is the purpose of the study?

It is to explore some of the processes which contribute to health visiting outcomes, and which could have a bearing on initial and post basic educational courses for health visitors

What will be involved if I agree to take part in the study?

You will be invited to talk about how you view interpersonal relationships in health visiting, how you think you've changed since qualifying and how your life events may assist you in achieving health visiting outcomes.

This will take approximately an hour, and would be tape recorded if you are in agreement. The tape will be erased after transcription and your name will not appear anywhere on the tape or transcript.

Can I withdraw from the study at any time?

Yes. You can tell me to stop the tape and we can erase the conversation, or you can contact me at any time.

What other information will be collected in the study?

Nothing else about you, other than what you tell me during the discussion, but I may invite you to make comments about the transcript, or to meet in a small discussion group after the majority of individual interviews are completed.

At a later date I may seek views from other health professional about their perceptions of health visiting, or from health visiting lecturers about the education and training of health visitors.

Will the information obtained in the study be confidential?

Yes. There will be no identification of anybody in the study.

Will anyone else be told about my participation in the study?

No-one will be told of your participation in the study

What if I wish to complain about the way in which the study has been conducted?

If you have any cause to complain about any aspect of the way in which you have been approached or treated during the course of this study, you should write to the University of Warwick, Department of Continuing Education.

Thank you for taking the time to read this and for volunteering to participate in this research.

I understand the purpose of the interview and am willing to participate

signature.....

date.....